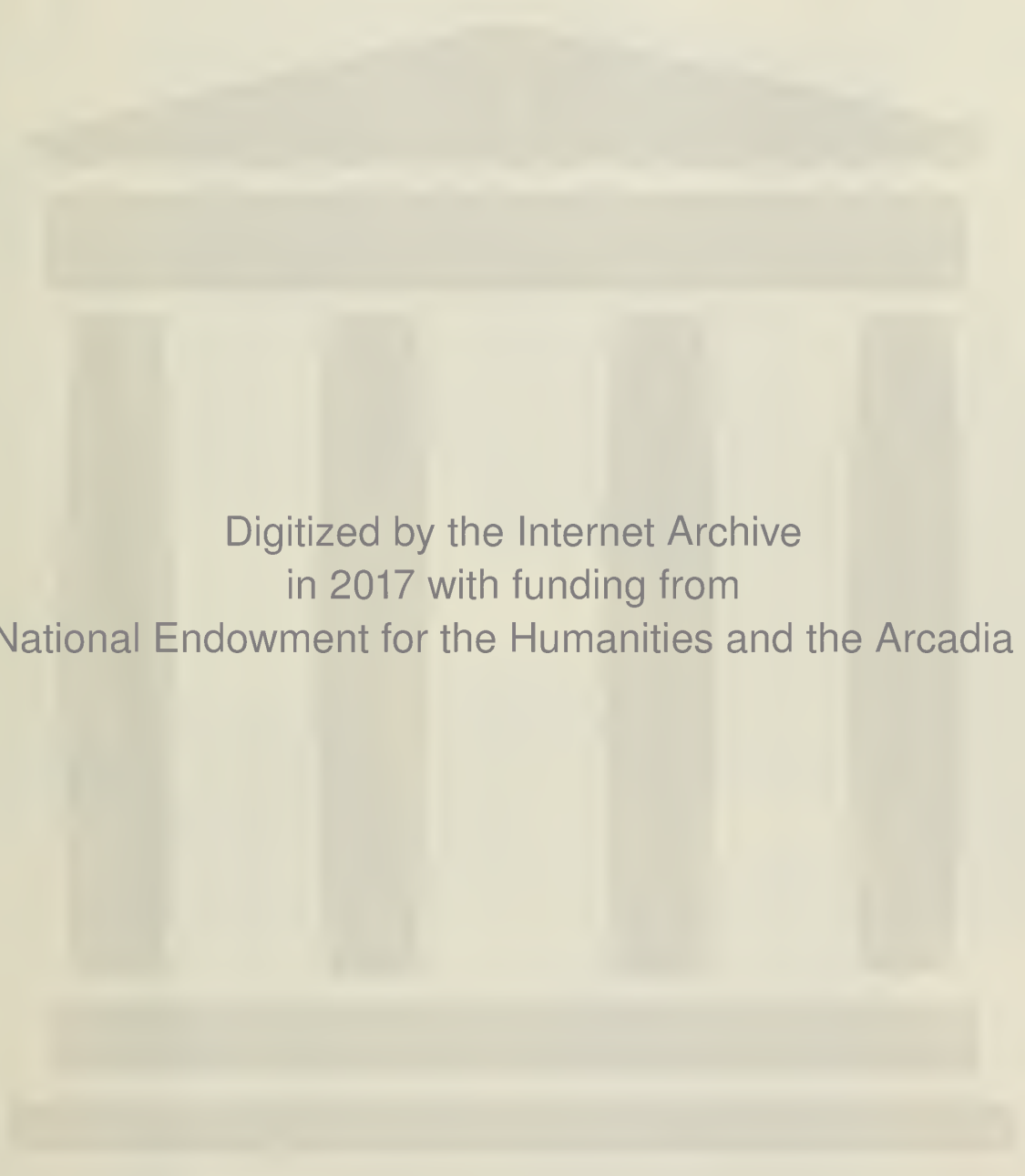


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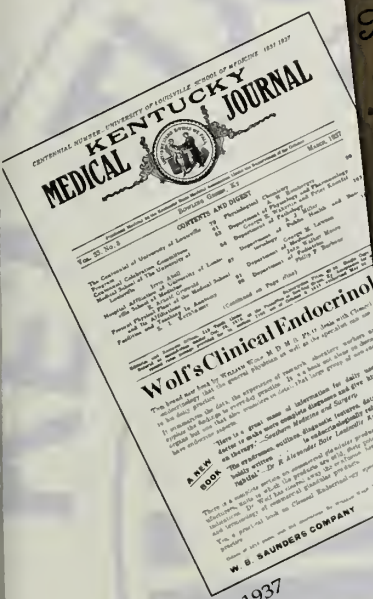
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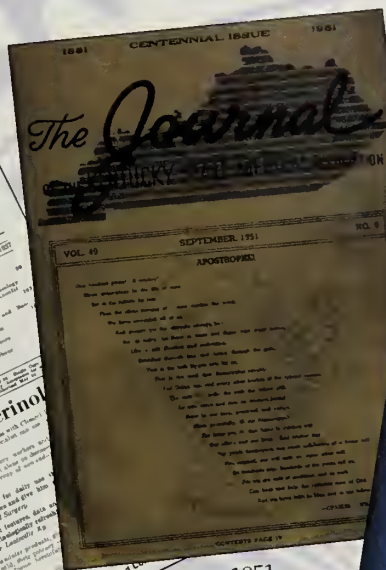
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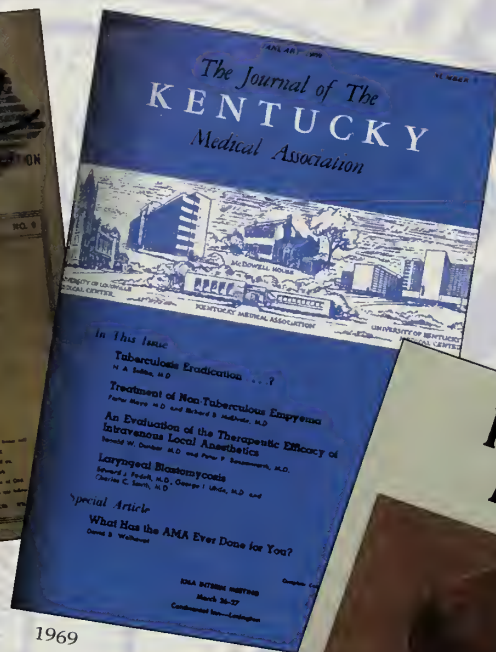
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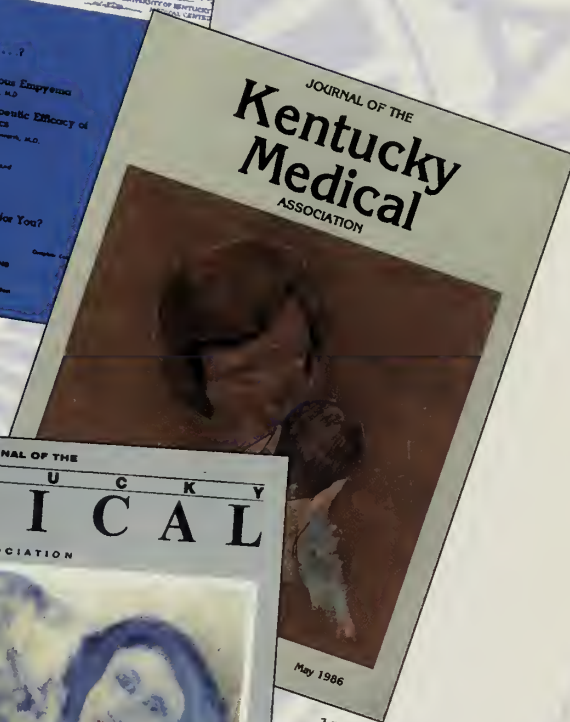
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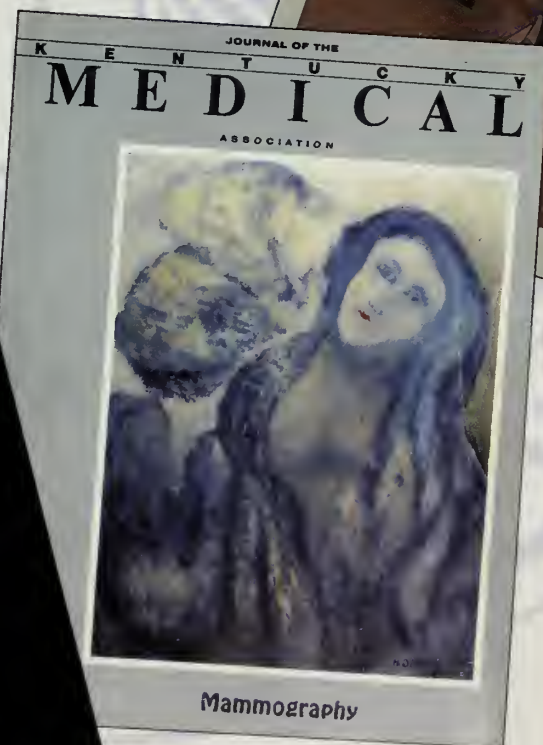
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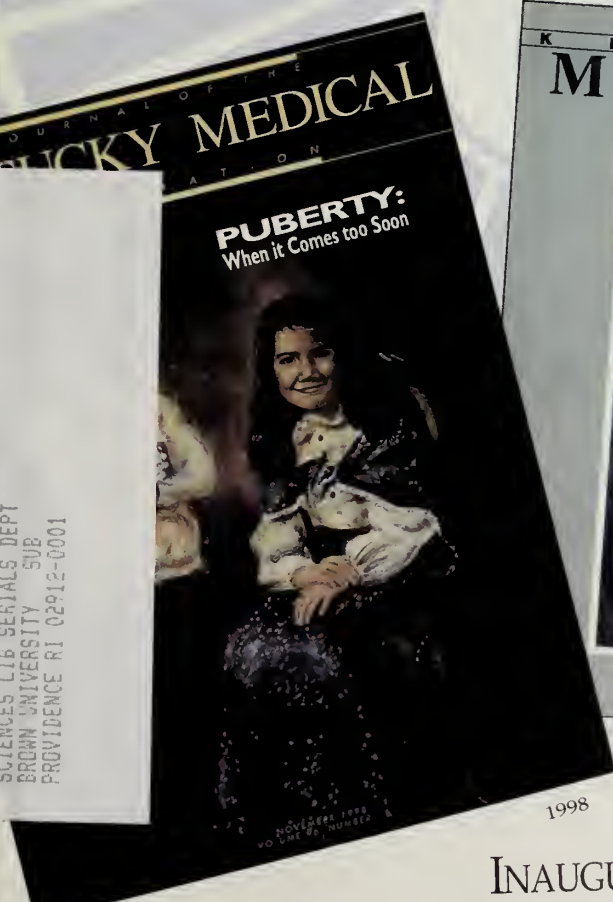
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INAUGURAL ISSUE OF YOUR REDESIGNED JOURNAL

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In 1978, we took a stand.

During the medical malpractice insurance crisis of the 70's, we worked with the Kentucky Medical Association to create an insurance company managed by physicians for physicians. Kentucky Medical Insurance Company (KMIC) was founded on the principles of strength, stability, service and commitment to physicians in Kentucky. We continue to stand by these principles today.

In 1987, we took a stand.

When an insurance company moved into the state in the 80's, offering threateningly low premiums, we took a stand. KMIC requested discussions and meetings with several public and governmental agencies. We wrote letters outlining what could happen when an insurance company does not charge adequate rates, and is not

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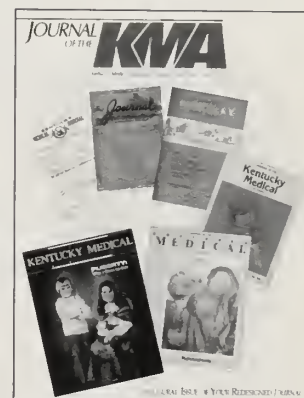
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Welcome to your newly designed Journal of the Kentucky Medical Association. This month's cover reflects several designs from the past. See page 11 for brief comments from Editor A. Evan Overstreet, MD, on this effort to be of greater service to you, our readers.

Design by Lee Wade of Eminence, Kentucky.

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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Periodical postage paid at Louisville, KY and additional offices. Yearly subscription rates: \$35 domestic; \$45 foreign. Single issues \$4 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222. Telephone 502/426-6200; Fax 502/426-6877.

Listed in *Index Medicus*. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

EDITORIAL AND ADVERTISING:

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MOVING ON

In December, we attended the interim American Medical Association meeting and Don Barton, MD, Senior Delegate from Kentucky will be reporting to you soon. However, it was interesting to see the tremendous debate going on at these meetings and the give and take by Delegates. Every issue of importance to your practice was discussed, debated and some action taken. The AMA House of Delegates is truly one of the most Democratic bodies in the world.

The primary focus of the interim meeting was the discussion and adoption of the Ad Hoc Committee on Structure, Governance and Operations. Significant changes were made in the management and board operation of AMA, which hopefully will prevent a future "Sunbeam" from reoccurring. Human frailty dictates that errors and mistakes do occur, but that's not to say that one should not learn from their mistakes. Our medical system is built on that very concept, and in the embodiment of peer review which we believe enhances our practices and increases quality of patient care. Peer review engages us in discussion of our colleagues' experiences. The AMA adopted the Committee report which was truly an exercise in Peer Review. But it's time to move on. Self-flagellation, finger pointing, and "circling the wagons and shooting at ourselves" is not in the long-term best interest of the profession, practice of medicine, or AMA. Much needs to be done, including the adoption of Patient Protection, revision of the E&M Codes and revamping Medicare. Let's concentrate on the real problems.

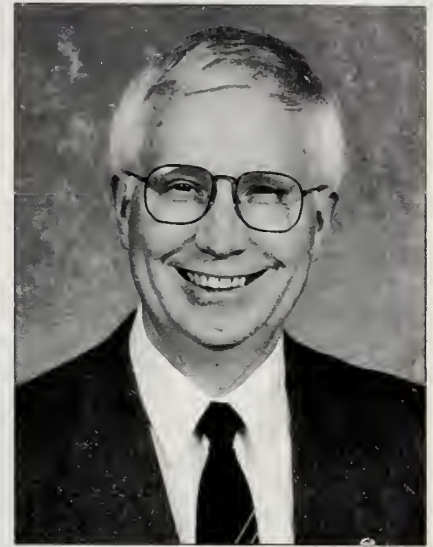
On the state level, issues including the definition of a "physician office," patient

protection-provider fairness regulations, and proposed Anthem networks top the list of important issues confronting medicine. We are at work trying to resolve these problems and we urge you to watch your "Communicator" and other KMA publications and letters for updates.

In December, it was my pleasure to be the guest of staff and students at the Pikeville Osteopathy Medical School. We are urging them to get involved in the practice and politics of medicine and join us as we work to protect the profession and our patients. We were well received and grateful for the cooperation and support of Dean John Strosnider, DO.

The Kentucky General Assembly has met in their organizational session and selected leadership for the 2000 Kentucky General Assembly. We will be working with them and the Administration throughout the interim period.

The KMA is making every effort to bring the Association to you. Various practice seminars will be scheduled in your regions and we urge you to take advantage of these opportunities. This is YOUR KMA and we urge you to call us if we can assist you or provide answers to your concerns.



*Much needs to be done. . . .
Let's concentrate on the
real problems.*

Donald R. Stephens, MD
KMA President

Who's

WATCHING OUT For You?



From providers to community leaders, researchers to educators, and government officials to citizens, the National Rural Health Association's members seek to improve the health care of rural Americans through advocacy, communications, education and research.

Shrinking populations, stalled economic conditions, reduced health care dollars and elderly patient bases create challenges for communities and health care providers alike. In rural communities across America, concerned community leaders and citizens pool their energies to make high-quality health care available and affordable.

The National Rural Health Association and its members work to overcome rural health care challenges. They focus on reforming and strengthening health care to meet the needs of rural areas. While government funding continues to dwindle, this multi-disciplinary group of health professionals and leaders finds innovative solutions to complex dilemmas.



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MONITORING **Medicine**

NEWS FOR KENTUCKY PHYSICIANS

Certificate of Need and the Physician Office Exemption

Attorney General Albert B. Chandler III has been requested to issue a legal opinion concerning the ability of physicians to implement an Ambulatory Surgery Center pursuant to KRS 216B.020(2)(a) commonly referred to as the "Physician Office Exemption." The exemption was an original component of Senate Bill 283, which was adopted in 1972 by the Kentucky General Assembly. Over the years, numerous attempts have been made to remove the physician office exemption, or at least to define a "physician office." KMA has traditionally opposed and been successful in defeating these efforts. Several opinions have been rendered by previous Attorney Generals, and in at least one instance the opinion appears to conflict with a previous Attorney General's opinion. While an Attorney General's opinion does not carry the "full force of the law," it can have considerable standing within the legislative and regulatory arena. In addition,

it may precipitate attempts to remove or narrowly define the exemption.

The Attorney General has been asked to address the following:

- May a physician establish an ambulatory surgery center as part of his or her private practice or clinic without obtaining a CON?
- Is a physician's ambulatory surgery center that is exempt from CON requirements also exempt from licensure by the division of Licensing and Regulation pursuant to KRS 216B.020(3)(a)?
- May a physician's ambulatory surgery center that is exempt from CON requirements voluntarily submit to licensure by the Division of Licensing and Regulation of the Cabinet for Health Services?
- Does the requirement that a physician obtain a CON and license prior to the implementation of an ambulatory surgery center as part of a private office or clinic constitute an illegal limitation upon a physician's professional medical judgment concerning the manner in which he or she performs surgery? Does this requirement violate the Kentucky Medical and Osteopathy Practice Act?

The KMA House of Delegates has addressed the CON issue on numerous occasions, notably in 1978, 1979,

MONITORING Medicine

1990, 1992, 1996, and in 1997. The House of Delegates has clearly stated its opposition to any changes in the CON law that would "jeopardize" the exclusion of physician offices from the regulatory power of CON. In 1996 the House of Delegates referred Franklin County Medical Society Resolution 96-118 to the Board of Trustees. After an extensive study, the Board of Trustees adopted the following, which was subsequently adopted by the 1997 House of Delegates:

"The KMA Board of Trustees reaffirms and endorsed the retention of the CON law with an option of reviewing modifications as periodically proposed. The KMA continues to support the preservation of the private physician's office exemption."

Attorney General Chandler's office has requested that KMA comment upon the inquiry and provide information on its position. The KMA Quick Action Committee and General Counsel are developing a position on each of these issues delineated by the inquiry.

AMA Asks Justice Department to Challenge Aetna/Prudential Merger

The American Medical Association asked the Department of Justice on Friday, December 18, to challenge the proposed merger of Aetna/Prudential, calling the merger anti-competitive and a threat to the freedom of patients and employers to choose their health care plans.

"The market power that would be created or exacerbated by this merger would limit the choices of patients and employers, reduce competition, and further erode the ability of physicians to make medical decisions based on science and the medical needs of their patients, not share price," AMA Executive Vice President, E. Ratcliffe Anderson, Jr, MD, said in his letter to Joel I. Klein, head of the department's Antitrust Division.

"We are convinced that 'bigger' in the health care market place does not always result in 'better' outcomes for patients. Choice is particularly critical in a rapidly changing industry such

as health care. Only in a competitive market can patients make effective choices about the plans which will best serve the health needs of their families."

According to Anderson, the Aetna/Prudential merger would "create a dominant entity" and would allow the new company to "drive medical decisions based on financial and stockholder expectations."

"Any increase in Aetna's market power would further diminish the ability of patients to receive the quality of care they seek from physicians dedicated solely to their best interests," Anderson wrote.

Anderson's letter is the latest effort in an ongoing AMA campaign aimed at correcting and exposing managed care abuses. For the past year, the AMA has attempted to convince Aetna to ease harmful practices that are not in the best interests of patient care and to adopt practices that will restore trust on the part of patients and physicians.

INAUGURAL ISSUE OF YOUR REDESIGNED JOURNAL

Dear Colleague:
Welcome to the inaugural issue of your redesigned *Journal of the Kentucky Medical Association*.

The cover of this debut issue reflects several designs from the past, a recollection that the *Journal* has undergone many changes over its long and distinguished career. The unique KMA logo featured in the masthead was designed by Lee Wade of Eminence, Kentucky, and has been widely incorporated into most KMA designs and communications.

The *Journal's* new layout is designed to streamline the reading process and enhance visual appeal. The print has changed to allow for easier scanning of articles. Adhering to *Journal* policy to be a vehicle for education, scientific articles submitted by Kentucky physicians will retain their prominence and publication as uninterrupted units, thereby facilitating quick reference.

The Kentucky Medical Association dedicates itself to providing physicians the tools needed to compete effectively in medicine's changing environment. Through a coordinated communications process, with the *Journal* as the flagship publication, KMA strives to provide current and accurate information essential to the physicians of Kentucky.

As the page turns to the 21st Century, the Editorial Board plans to preserve the tradition of excellence established for the *Journal* in 1903. We covet the input of you, our readers, so that we might respond specifically to your needs, concerns, and wishes. We hope you are pleased with this new and improved version of "your *Journal*."

A. Evan Overstreet, MD
Editor

BRACHYTHERAPY IN EARLY PROSTATE CANCER— EARLY EXPERIENCE

B. Oliapuram Jose, MD; James L. Bailen, MD; Frederick H. Albrink, MD; Greg S. Steinbock, MD;
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Use of brachytherapy with radioactive seeds in the management of early prostate cancer is commonly used in the United States. The early experience has been reported from the prostate treatment centers in Seattle for the last 10 years. In this manuscript we are reporting our early experience of 150 radioactive seed

implantations in early stage prostate cancer using either Iodine 125 or Palladium 103 seeds. The average age of the patient is 66 years and the median Gleason score is 5.4 with a median PSA of 6. A brief description of the evolution of the treatment of prostate cancer as well as the preparation for the seed implantation using the volume study with ultrasound of the prostate, pubic arch study using CT scan of the pelvis and the complete planning using the treatment planning computers are discussed. We also have described the current technique which is used in our experience based on the Seattle guidelines. We plan a follow-up report with the results of the studies with longer follow-up.

Prostate cancer is the leading form of cancer among American men and the second most frequent cause of death from cancer, exceeded in males only by lung cancer.¹ The ideal treatment of localized prostate cancer remains a topic under considerable debate. Patients are deluged with conflicting information regarding the "ideal" treatment for prostate cancer. Additionally, because there is not proof that early detection and treatment translate into a decrease in mortality, it is often stated that patients who are untreated do just as well as those who received treatment. Interestingly, the expected rate of prostate cancer for 1997 was calculated to be

334,500; however, this has recently been adjusted to 210,000 and the mortality rate has been reduced by 6.3%. These figures would indicate that both the rates of incidence and death are decreasing and that this may be due to earlier detection and/or better treatments.² Recommendations for treatment have included: external beam radiation, radical prostatectomy, cryotherapy, observation, androgen deprivation, chemotherapy and brachytherapy.

HISTORY OF BRACHYTHERAPY

Brachytherapy is the oldest therapy technique for treating prostate cancer.³ "Brachytherapy" comes from the Greek root word meaning short and is used to describe treatments with radioactive sources or materials placed close to the tumor. The first attempt at brachytherapy for prostate cancer was in the early 1900s when radioactive tubes were inserted through the urethra into the prostate gland.⁴ In 1952 interest was revised in this type of treatment when Flocks et al injected interstitial colloidal gold into the prostate during open operations.⁵ The interest in brachytherapy waned until 1972 when Whitmore et al described their technique of open implantation of I-125 seeds.⁶ This was originally received with great enthusiasm; however, due to poor cure rates the procedure fell from favor. The modern era of prostate brachytherapy began with Dr Hans Holm who conceived the idea of implanting radioactive sources transperineally using transrectal ultrasound guidance.⁷ In the late 1980s the technique of transperineal seed implantation was dramatically improved through the work done by Drs Ragde, Blasko, and Grimm, et al.⁸⁻¹⁰ Their technique known as the "Seattle Method" forms the basis of our implantation technique. This

relies on careful determination of the prostatic anatomy prior to the implant and pre-loading of the needles with radioactive sources before the actual procedure. In the United States approximately 30% of patients with prostate cancer are being treated with radical surgery, 30% with external beam radiation, and 4% with interstitial seed implants.¹¹ However, the number of patients presenting for implantation is increasing dramatically. This is primarily due to the increasing evidence that the results compare favorably to standard treatments for prostate cancer and can be accomplished in a less invasive, less deforming, and less expensive manner. It was precisely because of these conditions that the authors decided to begin performing transperineal seed implantation for the treatment of organ confined prostate cancer. Our first implant was performed in December 1996 and we herein report our early experience.

DECISION TREE

After the establishment of the diagnosis of prostate cancer in any patient, the decision must be made as to whether the patient is an implant candidate. This is accomplished using the monogram depicted in the Figure. The patient's PSA, clinical stage, Gleason Score, and overall general status impact whether or not there is a high likelihood that the carcinoma is confined to the prostate gland. For Clinical Stage T1c or T2a lesions, Gleason score less \leq VII, and PSA \leq 10, patients are suitable for transperineal seed implantation alone. In some cases, a combination of external beam irradiation followed by seed implantation is in the patient's best interest. This generally includes patients with a Gleason Score of VII or above, PSA 10 or above or clinical stage T2b (1998 AJCC Staging). In that case, the patient initially receives 4500 cGy to the whole pelvis using a four-field technique with 18-MV photons. Custom Cerrobend blocks are placed in the treatment portals on a daily basis to reduce dose to normal tissues as much as possible. CT treatment planning is utilized to assure optimum dose distribution. Target volume includes the prostate as well as the periprostatic,

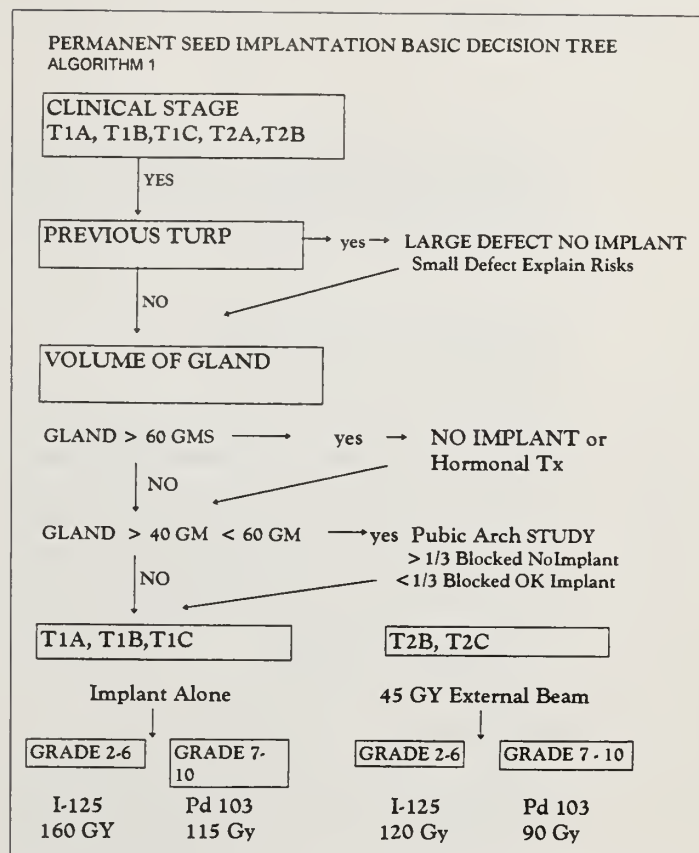


Figure.

obturator, and external iliac nodal groups. Every effort is made to spare the posterior rectal wall and bladder wall as much as possible. In some patients androgen blockade is attempted to reduce the size of the gland or if there is a delay in obtaining seeds.

VOLUME STUDY PRIOR TO PERMANENT SEED IMPLANT

In order to determine the size of the prostate and, therefore, the number of seeds required to perform a successful implant, a volume study is performed. The patient is placed in the dorsal lithotomy position. Using the ultrasound stabilizing device and stepping unit, the B&K 1084 transrectal ultrasound probe is placed into the rectum and the prostate is visualized. Axial images are obtained with the treatment planning software demarcating a grid pattern every 1 cm on the images which will be utilized for treatment planning. Images are obtained from

the base through the apex in the axial plane. A single longitudinal image is also obtained to verify the length of the gland and any protrusion of the gland into the bladder.

RADIATION THERAPY TREATMENT PLANNING

The serial ultrasound images are placed into the treatment planning computer. Using the 3-D treatment planning software the dosimetrist, given a prescription from the physician, determines number of Iodine-125 or Palladium-103 seeds to be utilized and the strength of the individual seed. These are then ordered and the surgery date is scheduled.

IMPLANT TECHNIQUE

On the day of surgery the seeds are pre-loaded into carrier needles which will be placed into the prostate gland under ultrasound guidance. The patient is then anesthetized with either a general or spinal anesthetic and placed in the dorsal lithotomy position. The ultrasound probe is placed into the rectum with images corresponding exactly to those of the volume study. A template for needle placement is then placed against the perineum. Once the position of the prostate gland is confirmed at the base, mid-gland and apex, the procedure is begun. Individual needles are inserted into the gland beginning anteriorly and working posteriorly according to the radiation therapy plan, at each level checking to be sure that the position of the gland is accurate. Once the seeds have been implanted, the ultrasound probe is removed and using fluoroscopic guidance, any additional seeds are placed into areas of the gland as a boost to the tumor. The patient then undergoes cystoscopy to remove any seeds inadvertently placed in the bladder. He is sent to recovery and discharged.

Discharge instructions are given to the patient. Typical precautions include an ice pack to the perineum, pain medications, and alpha agents to help with urination. The patient can

expect some transient hematuria, possible acute bladder and rectal spasms; however, for the most part, patients are up and about in 24 hours. One month after the implant, post implant dosimetry x-ray simulation films and CT scans are obtained. Isodose plans are generated which detail the actual dose delivered to the gland.

MATERIALS

At the present time, we have performed 150 radioactive seed implants. The average age of the patients is 66 years, with a range of 52 to 83 years. Sixty-seven percent have T1 disease, and 33% have T2 disease. The median Gleason score is 5.4 (range 4-9), and median PSA is 6 (range 2.4-24.3). Implant dose is prescribed as the Minimum Peripheral Dose. For I-125, MPD's of 160 Gy (implant alone) and 120 Gy (EBR + implant) are prescribed. For Pd-1203, MPD's of 115 Gy (implant alone) and 90 Gy (EBR + implant) are prescribed. About one-third of the patients received combinations of external beam and implant. The patients are followed with clinical examinations and serial PSAs as per Seattle schedule. We also follow these patients on a regular basis for the evaluation of the acute and late side effects of this treatment. We plan to report on the results and side effects as data collection is completed.

DISCUSSION

Although no randomized prospective trials have been performed comparing radical prostatectomy to external beam radiotherapy (EBR), there is ample data to indicate that the two modalities are equivalent. Data from RTOG 7706 show a 10 year disease specific survival of 86%, and a local control rate of 87%. In addition, EBR is much less likely to cause permanent impotence. Most series record an impotence rate of 20% to 30%, and the risk of other severe complications is less than 5%. Even with the success of EBR, continued research into the utilization of radioisotopes has led to treatment techniques which may offer the same chance for cure, but with even fewer side effects.

Radioactive seed implantation is a treatment technique offered to men who have prostate carcinoma confined to the gland. This treatment option allows for the delivery of a high dose of radiation to a very localized region, thereby sparing many normal tissues from radiation injury. Placement of radioactive materials into the prostate is not a new concept, and has been investigated decades ago. Its use did not become mainstream due to technical difficulties in actually placing the radioactive seeds into the gland. The advent of computerized tomography and sophisticated computer planning programs has allowed for accurate delineation of the prostate volume, and has taken the guesswork out of deciding how much radiation is necessary to properly treat the entire gland. As well, a transperineal approach is used to place the seeds, making this an outpatient procedure with rapid recovery time.

Specifically, the prostate seed implant technique has been intensely investigated primarily by Dr John Blasko and Dr Kent Waller of the Northwest Tumor Institute. Their data has been collected over the past 8 years and represents the most extensive database available for analysis. Additionally, their experience in performing this procedure has been taught to urologist and radiation oncologists nationwide.

The Seattle group has reported the 10-year disease free survival after transperineal sonography-guided iodine-125 brachytherapy with or without 45-gray external beam irradiation in the treatment of patients with clinically localized, low to high Gleason grade prostate carcinoma. They analyzed the results of 152 consecutive patients who were treated in the above fashion. The clinical stage was T1-T3, low to high Gleason grade and the treatment was carried out from January 1987 to June 1988 at Northwest Hospital in Seattle, Washington. Their median age was 70 years (range is 53-92 years). Of the 152 patients 98 (64%) received an iodine-125 implant alone, and this is Group 1. The remaining 54 patients (36%) who were judged to have a higher risk for extraprostatic extension were treated with 45-gray of external beam radiation to the pelvis followed by seed implanta-

tion as a boost. This is Group 2. No patient underwent lymph node sampling and none received androgen ablation therapy. The average preoperative prostatic specific antigen was 11.0 ng/mL and the Gleason grade was 5. The median post treatment follow-up was 119 months (range 3-134 months). The overall survival at 10 years after treatment was 65%. At last follow-up only 3 of the 152 patients (2%) had died of prostate carcinoma. Sixty-four percent remained clinically and biochemically free of disease at 10 years of follow-up and with an average PSA value of 0.18 ng/mL (range 0.01-0.5 ng/mL). In these patients a period of 42 months was required to reach the average PSA (0.5 ng/mL). The median to last PSA follow-up was 95 months. Only 6% of the patients developed a bony metastasis. The conclusion is that percutaneous prostate brachytherapy is a valid and efficient option for treating patients with clinically organ-confined, low to high grade Gleason grade prostate cancer. They compared the surgical as well as external beam radiation treatment from the current literature in the article.¹²

Several years of follow-up will be required to sufficiently analyze the data with regards to patient outcomes, although the standardization of this procedure should allow for outcomes similar to the NWTI data. Given the high rate of success of this procedure as well as its lower cost compared to surgery and full course EBR, radioactive seed implantation is quickly becoming the treatment modality of choice for localized prostate cancer. Continued research and refinement should only enhance the results obtained thus far.

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ACKNOWLEDGMENT: JoAnn P. Lindeman for preparation of this manuscript.

USE OF HIGH FREQUENCY OSCILLATORY VENTILATION (HFOV) FOR RESPIRATORY DISTRESS SYNDROME (RDS)

Dan L. Stewart, MD; Tony Hilbert, RRT

A major goal of both animal and human research in neonatal respiratory disease has been to reduce the incidence of ventilator-associated lung injury. Despite advances such as surfactant replacement therapy and improved method and delivery of mechanical ventilation of the neonate, ventilator-related injury remains a significant cause of morbidity and death in patients who require assisted ventilation.

MECHANISM OF VENTILATOR- ASSOCIATED LUNG INJURY

Pulmonary injury is initiated in a surfactant-depleted lung with the first tidal volume breaths, especially if large tidal volumes are used. This injurious process spreads rapidly throughout the lung as tidal volume breaths attempt to fill other surfactant-depleted alveoli. Although the use of surfactant replacement therapy has significantly impacted both the pulmonary management and outcome of small infants with natural or acquired surfactant deficiency, this alone is not the answer. While administering surfactant helps, there is not a "perfect" method of delivery. Some alveoli will receive surfactant and in turn require less opening pressures with improved compliance, while others will fail to receive any surfactant. These alveoli continue to require significant opening pressures and thereby remain highly susceptible to injury. Once these alveoli are opened during a tidal volume breath, they tend to collapse on exhalation and the process is repeated with each breath delivered. This sequence results in barotrauma and lung injury.

Case Presentations

The following are two examples of the early use of high frequency oscillatory ventilation (HFOV)

in the very low birth weight (VLBW) premature infant in the neonatal intensive care unit (NICU).

Case 1. This 594 gram male infant was born to a gravida 4 para 3 white female via C-section at an estimated gestational age of 23 weeks. The Apgar scores were 6 and 7 at 1 and 5 minutes respectively. The infant required intubation and positive pressure ventilation in the delivery room, and he was transported to the NICU on conventional mechanical ventilation (CMV) via a transport incubator. The infant was immediately placed on HFOV at the following ventilator settings: mean airway pressure (MAP)-10 cms/ H_2O ; Amplitude (Amp)-20; Hertz (Hz)-15; and FiO_2 -80%. His first arterial blood gas (ABG) was: pH-7.39; pO_2 -57; pCO_2 -31; HCO_3 -19.

This patient received four doses of Surfactant (Ross Laboratories, Columbus, Ohio) and three doses of indomethacin for ductal closure and central nervous system prophylaxis for intraventricular hemorrhages (IVH).¹⁹ At <24 hours of age, the infant had weaned to the following ventilator settings: MAP-7; Amp-12; Hz-15; and FiO_2 -55%. After 16 days of HFOV, the infant was placed on CMV at low settings and was weaned gradually. The patient was discharged home at a postconceptual age of 37 weeks (before his estimated date of delivery). Complications of prematurity included a Grade II IVH, retinopathy of prematurity requiring laser surgery, and patent ductus arteriosus ligation. There were no findings of periventricular leukomalacia (PVL) on the last head

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ultrasound, but the infant did require supplemental oxygen at the time of discharge for mild chronic lung disease (CLD).

Case 2. This 1000 gram white male infant was born to a gravida 2 para 0 female via C-section at an estimated gestational age of 27 weeks. The patient was one of a set of quadruplets. The mother was pretreated with a course of betamethasone prior to delivery. Apgars were 7 and 8 at 1 and 5 minutes respectively. The patient was intubated in the delivery room and transported to the NICU on CMV via a transport incubator. Because of hypoxemia on CMV, the patient was switched to HFOV at the following settings: MAP-10; Amp-24; Hz-15; FiO₂-35%. ABG at 4 hours of age showed: pH-7.40; pO₂-59; pCO₂-41; HCO₃-25. This was a decrease from an FiO₂ of 90% on CMV.

This patient received three doses of Surfactant and three doses of indomethacin. After 11 days of HFOV, the infant was changed to CMV at moderate settings. The infant was discharged home on supplemental oxygen at a post-conceptual age of 39 weeks. One of the major complications of prematurity was retinopathy of prematurity that did not require treatment. The head ultrasound showed no signs of IVH or PVL.

DISCUSSION

It appears that changes in lung volume may be more important than changes in airway pressure in the propagation of lung injury. Clark et al² have proposed replacing the term barotrauma with the term volutrauma. In animals with healthy lungs, large tidal volumes damage the pulmonary capillary endothelium, the alveolar and airway epithelium, and the basement membranes. This mechanical damage causes fluid, protein, and blood to leak into the airways, alveoli, and lung interstitium, initiating a sequence that can lead to death secondary to progressive respiratory failure. The use of HFOV prevents lung injury by supporting adequate gas exchange with small tidal volumes that are less than the dead space. Using HFOV, lung volume is maintained above functional residual

capacity by the use of a constant distending pressure determined by end-expiratory or mean airway pressure and avoiding the cycle of inflation and deflation associated with CMV.

Among the smallest of VLBW infants, the incidence of respiratory failure requiring mechanical ventilation approaches 100%.² The respiratory failure seen in VLBW infants is usually the result of respiratory distress syndrome (RDS), as it is the most common lung disease treated in NICUs. The use of antenatal steroids to accelerate surfactant production and the routine use of postnatal surfactant replacement have had a major impact on RDS severity, but they have not eliminated the problem nor decreased the incidence of CLD.³

Based on animal experiments, most investigators believe that the use of HFOV in the management of neonates with respiratory failure reduces ventilator induced lung injury. In the premature baboon model of RDS, the use of HFOV reduces the occurrence of air leak, prevents the development of RDS, promotes uniform lung inflation, and improves gas exchange and lung mechanics.⁴ In rhesus monkeys with RDS, the use of HFOV improves gas exchange and reduces exudative edema.⁵ In comparison with CMV, HFOV reduces the amount of inflammatory mediators (thromboxanes and platelet-activating factors) and the number of leukocytes in lung lavage samples recovered from animals with acute lung injury.^{4,7}

Intuitively, most neonatologists envisioned HFOV to have its greatest impact on RDS, but thus far the results are perplexing. Animal studies almost uniformly show that pulmonary air leaks and ventilator-related lung injuries decrease and overall survival improves; yet clinical trials in neonates with RDS have not been convincing. Previous studies⁸⁻¹⁰ comparing high frequency ventilation (HFV) to CMV showed no clear benefit nor detriment due to HFV, even though gas exchange was maintained at lower proximal airway pressures. In a large, multicenter trial sponsored by the National Institute of Health (the HiFi trial),¹¹⁻¹⁴ 673 infants with RDS, weighing between 750 and 2000 g, received

either HFV or CMV. Not only was there no benefit due to HFV, but those infants treated with HFV were noted to have had more severe IVH and an increased incidence of PVL, pneumoperitoneums of pulmonary origin, and pulmonary air leaks. There were no significant differences in the incidence of CLD or in post-treatment pulmonary mechanics measurements. Another alarming finding was that the neurologic outcomes at 1-year follow-up were significantly worse in the HFV-treated infants. It is important to note that this study was completed in the pre-surfactant era combined with a minimum-pressure ventilatory strategy that failed to optimize lung volume. These factors certainly contributed to the study's lack of success.

A randomized trial by Clark et al¹⁴ in 1992 evaluated the impact of three different RDS ventilatory strategies: HFOV alone, CMV alone, and the combination of 72 hours of HFOV followed by CMV. The investigators found that the incidence of CLD, defined as persistently abnormal chest radiographs and supplemental oxygen required for longer than 30 days, was significantly reduced in those infants receiving HFOV alone with other outcomes being similar. The authors concluded that HFOV was as safe as CMV and may well lead to a decrease in the incidence of CLD.

There is now evidence that non-tidal ventilation causes less lung injury than does tidal ventilation, particularly when it is applied shortly after birth. Recent animal studies by Jackson et al¹⁵ have demonstrated a synergistic interaction of HFOV and surfactant treatment with reduction in lung injury. Froese et al¹⁶ also showed that optimizing alveolar expansion prolongs the effectiveness of exogenous surfactant therapy in the adult rabbit. These studies suggest that HFOV may be more effective now that we are in an era of routine surfactant replacement.

Any new therapy introduced into neonatal care to improve pulmonary outcome must do so without increasing morbidity or mortality. Based on previous reports, there is concern over the possible link of IVH and PVL, but this association has not yet been determined and should be either proven or dispelled. The recent mul-

ticenter Provo study¹⁷ showed that the overall frequency of abnormal cranial sonographic studies and the incidence of severe intracranial morbidity were the same for the two study groups. Other promising results included: (1) no mortalities in the HFOV study group, (2) a decrease in CLD, (3) a decrease in the use of surfactant, and (4) a decrease in hospital costs. Consistent with animal studies, the investigators concluded that their controlled trial in premature infants with RDS clearly indicates a beneficial role for the early use of an aggressive HFOV lung recruitment strategy after surfactant replacement therapy.¹⁷

A recently published study by Keszler et al¹⁸ compared preterm infants with uncomplicated RDS treated with high frequency jet ventilation (HFJV) to those treated with CMV. The major conclusions of this study were: (1) HFJV reduces the incidence of CLD at 36 weeks and the need for home oxygen in premature infants with uncomplicated RDS, (2) severe neuroimaging abnormalities (PVL and/or grade III-IV IVH) were not different between the CMV and the HFJV group, and (3) by using an optimal lung volume strategy, oxygenation was improved, there was a decreased exposure to hypocarbia, and the risk of neuroimaging abnormalities was decreased.

FUTURE DIRECTIONS IN THE USE OF HFOV

Although HFV has shown promise in avoiding the volutrauma/barotrauma associated with tidal ventilation, it is not the routine practice of most neonatal centers to utilize this therapeutic modality as a prophylactic management therapy. Most centers routinely use HFV only in a rescue mode. In other words, HFV is initiated in an effort to correct the damage that has already ensued as a result of conventional or tidal ventilation. To help address this issue, our institution is presently one of eight pilot sites for the "Non-Tidal vs Tidal Ventilation in Premature Infants Study." This study is attempt-

ing to document the feasibility of a large clinical trial, demonstrate effective protocol implementation, and document the safety of early HFOV use in infants weighing between 500 and 1200 g. The infants will be stratified by antenatal steroid use and birth weight and randomly assigned to receive either HFOV or spontaneous intermittent mandatory ventilation (SIMV), initiated prior to 4 hours of age. Each infant will be continued on the assigned mode of ventilation until reaching one of the following: (1) successful extubation, (2) death, or (3) development of early CLD defined as ventilator dependency at 28 days of age. At entry into our study, the infant must have received one dose of surfactant and it must be anticipated that the infant will require intubation and assisted ventilation for > 24 hours.

The exclusion criteria include the presence of significant heart disease (excluding patent ductus arteriosus, patent foramen ovale, or small ventricular septal defects), seizures or known neuromuscular disease, severe asphyxia, or the presence of severe hypotension. The infants will be managed with a tight protocol based on lung inflation as noted on chest radiographs. We will also use aggressive steroid therapy beginning at ≥ 10 days if the infant is ventilator dependent with $\text{FiO}_2 > 0.3$. This involves a 12 day course of decreasing doses of dexamethasone. Diuretics and bronchodilators will be used as deemed appropriate for infants with evolving CLD. The infants will be extubated to the Aladdin continuous positive airway pressure (CPAP) apparatus, which has minimal obstruction to the expiratory flow and, thus, should improve pulmonary mechanics.

CONCLUSION

With equipoise regarding HFOV versus tidal ventilation, the current literature and our anecdotal experience would support the early use of HFOV in infants with RDS. Upon completion of our multicenter study, we should have more comprehensive data in even the smallest of infants to support or renounce this ventilatory strategy in the future.

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TAX EXEMPT HOSPITALS' CONDITION IMPROVES WITH NEW PHYSICIAN RECRUITMENT GUIDELINES

by James C. Seiffert, Esq

I. INTRODUCTION

Tax-exempt hospitals and healthcare organizations have traditionally found it extremely difficult competing with their for-profit counterparts when it came to recruiting and retaining physicians. Constrained by restrictions imposed on tax-exempt organizations by the IRS, the tax-exempt healthcare provider finds its financial well being threatened as a result of its inability to provide attractive financial subsidies to physicians. Tax-exempts found that the playing field was not all that level—there was no question that the amount of money and the manner in which it was paid truly separated the taxable from the tax-exempt healthcare providers. This situation changed considerably with the issuance of The Physician Recruitment Guidelines (Revenue Ruling 97-21, 1997-18 IRB 8 (May 5, 1997)), which, for the first time, eased the restrictions on physician recruiting by tax-exempt hospitals. By eliminating dollar caps and time restrictions on perks such as signing bonuses, medical malpractice insurance and net income guarantees while at the same time recognizing aggressive recruiting techniques such as physician retention payments and crosstown

recruiting, tax-exempt hospitals are now in a much better position to pursue their charitable purpose without jeopardizing their tax exemption.

II. THE PHYSICIAN RECRUITMENT GUIDELINES: SUPPORT FOR MAINSTREAM RECRUITMENT TECHNIQUES

The Physician Recruitment Guidelines analyze five different hypothetical fact situations involving the recruiting of physicians by a tax-exempt hospital. In four out of the five situations, the IRS concluded that the tax-exempt hospital, based on the facts, furthered its exempt purpose by entering into the particular physician recruitment agreement. In the fifth, which involved a criminal conviction for violating the Medicare & Medicaid anti-kickback statute, the IRS held that the hospital's actions in violation of the law were contrary to its charitable purpose and its exempt status should be revoked.

The significance of these Guidelines to tax-exempt healthcare providers cannot be overstated. For the first time, the IRS has published, with

"New Internal Revenue Service guidelines provide a competitive playing field for tax-exempt healthcare providers in structuring financial incentive packages for both recruiting and retaining physicians."

some degree of specificity, those financial "perks" which are available to tax-exempt hospitals in their efforts to attract physicians. Going forward, all incentive packages will be analyzed on a case by case basis against a "commercially reasonable" standard. Equally important, the IRS has consented to the use of mainstream business practices which tax-exempt hospitals' counterparts have been utilizing for some time. A brief overview of the four positive recruitment situations illustrates the importance of this ruling.

Situation 1— Relocation to Rural Area

A rural area tax-exempt hospital hires a physician who recently completed a residency program to

establish and operate a full-time private OB/GYN practice in its service area and become a member of its medical staff. The physician enters into recruitment incentive agreement which provided him the following: (1) a signing bonus (no dollar limit identified), (2) the payment of his professional malpractice insurance for limited period (no set number of years identified), (3) office space at below-market rent in an office building owned by the hospital for a limited period, (4) guaranteed the physician's mortgage on his personal residence, and (5) provided the physician a loan to cover his start-up expenses associated with his private practice.

IRS held that the hospital demonstrated a particular need in its service area for the specialty practiced by the physician and the financial subsidies offered were a reasonable inducement to the physician to accept employment. In light of the circumstances, the hospital's actions furthered its charitable purpose.

Situation 2—Relocation to Economically Depressed Inner city

A tax-exempt hospital located in an economically depressed inner city hires a practicing pediatrician from outside its service area to relocate and establish a full-time pediatric practice. The physician obtained hospital staff privileges and in exchange, was required to treat a reasonable number of the hospital's Medicaid patients. Under the recruitment incentive agreement the hospital agreed to the following: (1) guaranteed the physician's private practice income for a limited

number of years, (2) reimbursed the physician for his "tail coverage" malpractice insurance, and (3) reimbursed the physician for moving expenses.

IRS concluded that the hospital clearly established the need such a physician and the recruitment package provided the physician reasonable financial incentives to relocate. With respect to the private practice income guarantee, the IRS found that the amount of the guarantee fell within the income range reflected in regional or national surveys earned by physicians in the same specialty. The hospital's charitable purpose was furthered by promoting and protecting the health of its constituents in the community.

Situation 3—Retention of Physician in Economically Depressed Inner City of Physician

A tax exempt hospital in the inner city hires one of its own medical staff physicians to provide obstetric services to Medicaid and indigent care patients. All retention incentives were identified in the written agreement. Specifically, the hospital agreed to reimburse the physician for the cost of one year's professional liability insurance.

Once again, the IRS determined that the hospital adequately demonstrated that: (i) an obstetrician was needed, (ii) the amount paid was reasonable and (iii) the public purpose which inured to the benefit of the community outweighed any benefit received by the individual physician.

Situation 4—Crosstown Recruiting in Metropolitan Area

A tax-exempt hospital lost two of its four radiologists. It required four radiologists to ensure adequate coverage and quality care. The hospital hires a physician on the medical staff of a crosstown hospital. The hospital offered to guarantee the physician's private practice income for a limited number of years and other incentives which were all set forth in a written agreement. The income guarantee fell within the compensation range reflected in regional or national surveys earned by radiologists.

IRS held that the hospital met its burden by establishing a particular need and the public purpose of providing adequate coverage and quality care outweighed any incidental benefit enjoyed by the physician.

III. THE PRACTICAL ASPECTS OF THE PHYSICIAN RECRUITMENT GUIDELINES

The Physician Recruitment Guidelines represent a new and more reasonable approach to physician recruiting by tax exempt healthcare providers. The Guidelines are important to both tax exempt healthcare providers and the physicians they recruit in three respects.

First, all arrangements will now be evaluated on a case-by-case basis analyzed based on the particular facts surrounding the transactions. Unlike prior IRS policies, there are no "per se

violations" or rebuttable presumptions imposed on the tax-exempt providers nor are hospitals subject to specific dollar caps or specific time limitations on the financial perks offered physicians. By establishing a particular public or hospital need and demonstrating the "reasonableness" of the total overall recruitment package, tax exempt organizations now have the latitude of providing incentives which, in the past, could only be offered by for-profit healthcare providers.

Second, the IRS has explicitly rejected its prior position that all recruited or retained physicians are "insiders" subject to the private inurement prohibition. Now, the healthcare provider can recruit physicians, regardless of whether or not they are on the medical staff, so long as they negotiate at "arm's length" and establish a fair and reasonable set of incentives. This approach is significant since both the board of directors and the physician, himself, will not be subject to personal liability by the imposition of the newly created "intermediate sanctions" imposed by Section 4958 of the Internal Revenue Code.

Third, it is quite clear from the Guidelines that the burden falls on tax-exempt healthcare providers' boards of directors must take an active role in structuring and negotiating the recruitment incentive packages. Anything less than an established, well-developed "hands-on" written recruitment policy can threaten the institution's tax-exempt status. By paying closer

attention to their respective recruitment programs and addressing the elements highlighted in the Guidelines, tax-exempt healthcare providers can pursue their charitable purpose when recruiting physicians without fear of retaliation by the IRS.

In order to meet this burden, boards of tax-exempt healthcare providers and their management should consider implementing the following steps:

(1) RECRUITMENT PLAN

Develop a comprehensive, written, broad-based physician recruitment program which sets out in clear and concise terms the institution's specific objectives and the steps to be taken to achieve these objectives.

The elements of a recruitment plan should contain the following: (i) a general assessment of the community and/or hospital needs; this assessment analysis will be based on its service area (i.e. rural, urban or inner city), its patient base (the Medicaid Medicare and/or indigent) and the direct or indirect threat to the health and safety of the service area; (ii) a well-developed standard of "reasonableness" as it relates to the hospital's needs and the cost-benefit analysis with a focus on the physician's value to the institution; this analysis should involve a review of industry and community compensation ranges in light of the actual services to be provided; (iii)

the development and maintenance of a database which incorporates national, regional or state need assessments or information regarding medical specialties as well as the local information compiled and analyzed by hospital management or paid consultants. Each tax-exempt healthcare provider should identify an individual or a committee to implement and monitor the program with periodic review by the entire board members.

(2) DOCUMENTATION OF RECRUITMENT EFFORTS

It is clear from the conclusions drawn from the Guidelines that it is the tax-exempt healthcare provider's burden to justify its recruitment activities. Consequently, it is imperative that the hospital clearly document its recruitment efforts. All matters should be discussed and then documented in board or committee minutes or reports. Furthermore, the tax-exempt healthcare provider's board must always be conscious of the fact that it must at all times comply with all federal and state laws and must show compliance with all federal laws, focusing on tax, social security, Medicare, etc.

(3) PHYSICIAN RECRUITS

With respect to each recruit, the board of directors or its recruitment committee should insert into its board minutes the factors identified in recruiting the particular

physician and the specific discussion that went into the identifying of the hospital's needs. This discussion should analyze both the tangible and intangible benefits (ie, fulfill community or hospital needs, increase effectiveness and efficiency and productivity, increase rotational capabilities associated with hiring the particular physician). Finally, the minutes should document the evaluation of the financial package offered identifying those amounts which require repayment either in kind or in case, and those which serve to subsidize the physician's relocation and how it was eventually justified. The board and its management can and should evaluate the increase in patient care that will result from the additional services provided by the physician. While it is not unlawful or incorrect to record the anticipated increase in patient admissions, it should be done on the basis of the service area, the number of potential

patients within the area and the percentage of such patients that will require the particular medical services.

(4) EMPLOYMENT AGREEMENT

Once the hospital and the particular physician agree on the terms of employment, it should proceed to prepare and execute a written agreement. The agreement should not only contain the particular financial incentives but also specifically identify the particular duties and responsibilities of the physician. A simple handshake is not sound practice. For both business and tax reasons, the arrangement should be put in writing after engaging arm's length negotiations with the physician and his or her independent counsel. The physician's specific duties and tasks should be identified as well as the hospital's particular expectations.

IV. CONCLUSION

With the aid of the Physician Recruitment Guidelines, tax-exempt hospitals and healthcare providers can now venture into the marketplace and compete against for-profit providers when recruiting and retaining qualified physicians. If tax-exempt healthcare providers do their homework by developing a legitimate physician recruitment program which includes both a community and hospital needs assessment and an objective, business-like approach to evaluating the particular cost-benefit associated with a potential physician/recruit, they can accomplish their objectives without jeopardizing their tax-exempt status. No longer are reasonable incentive compensation packages offered pursuant to physician recruitment programs in conflict with the tax-exempt hospital and healthcare providers charitable purpose.

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Daniel P. Garcia, MD

INHALE DEEPLY... IT'S SAFE

Bronchial asthma may be termed Chronic Desquamative Eosinophilic Bronchitis. Numerous studies and investigations over the last 10 to 15 years have now demonstrated that what we once regarded largely as a disease of airway smooth muscle resulting in intermittent bronchospasm is in reality a chronic inflammatory disorder of the lung with superimposed changes resulting in a spectrum of signs and symptoms to include cough, wheeze, to overt respiratory failure. Activated T-cells, eosinophils, mast cells, and resultant cytokines are pivotal players in the overall inflammatory process, even in patients with relatively mild asymptomatic asthma. These events lead to increased vascular permeability, epithelial damage, stimulation of mucous secretory glands, hypertrophy of smooth muscle, activation of neural reflexes, central and local, which may result in permanent airway remodeling.

Since airway dysfunction in asthma is a result of inflammation, it is not without surprise that guidelines for the management of this condition have focused on this aspect of the disease. Thus, much attention has been directed toward those

pharmacologics which have an impact on lung inflammation. Although sodium cromolyn and nedocromil sodium have been viewed as less strong anti-inflammatories, a great deal of attention has been given to the use of inhaled corticosteroids in an attempt to lessen morbidity and mortality and to decrease dependency upon systemic steroid use. In fact, both national and international guidelines for asthma management recommend, without reservation, earlier and more widespread use of inhaled corticosteroids.

There have been a number of studies to support the use of continuous corticosteroids over the chronic use of B-agonists alone, which become less effective with chronic use. Some authors have suggested that delaying the introduction of appropriate anti-inflammatory therapy may actually decrease their subsequent effect on bronchial hyper-responsiveness due to airway remodeling.

Corticosteroids are the most efficacious anti-inflammatories currently available. Inhaled corticosteroids have become the first line therapy for the child or adult with mild persistent to severe persistent asthma, as a result of their ability to act at the cellular level to alleviate

the underlying inflammatory process. Systemic corticosteroids on the other hand are reserved for moderate to severe exacerbations to gain rapid control of the disease process and to prevent recurrent episodic flares.

Our aims in asthma therapy should include: (1) decrease symptoms and exacerbations; (2) reduce morbidity and mortality; (3) normalize lung function; (4) cost-effectiveness; (5) prevent airway remodeling; (6) maintain or attempt to maintain a normal lifestyle with minimal or no adverse side effects.

Despite extreme anxiety and fears propagated by the media and the access to medical information by the patient population, it can be said that, in general, inhaled corticosteroids are safe and well tolerated at recommended dosages. Their efficacy has been well proven and balances out the potential but slight risk of adverse reactions. Much concern has been directed toward inhaled steroids and growth rates in children, which are in reality highly variable. Most studies in the literature to date on the use of inhaled steroids in children fail to demonstrate an adverse effect on linear growth, but growth delay has been suspected in some. Keeping in mind that children

with poorly controlled asthma may demonstrate a greater delay in growth patterns anyway, one is then faced with identifying those patients in which the benefits of medicating far outweigh any potential risks. Effects on linear growth in children from inhaled steroids are dose dependent, and we know that higher doses have been shown to have a greater effect on growth suppression but at the same time significantly less effect than oral steroids.

Therefore, it is recommended that while this issue needs to be more clearly defined, inhaled corticosteroids be used judiciously with monitoring of growth patterns while implementing stepping down therapy when feasible.

Therefore, in order to prevent adverse events in patients on

long term inhaled corticosteroids, the following are recommended measures: (1) prescribe all inhaled steroids with a spacer device (Aerochamber, Inspire-ease bag, etc) in order to optimize delivery and to decrease absorption and oral candidiasis, etc; (2) administer the least amount to control symptoms and normalize peak flow/pulmonary functions using stepping down/up therapy; (3) in growing children, monitor and document growth patterns using appropriate charts; (4) encourage all patients to rinse their mouth with plain water after each use; (5) consider calcium supplementation up to 1500 mg per day and vitamin D (400 units daily) for women in postmenopausal years and estrogen therapy if doses exceed 1000 mcg per day; (6)

consider as safe daily doses of less than 400-700 mcg for children and 1000 mcg for adults; (7) encourage continued monitoring in asthma management with regular follow-up visits at 1 to 6 month intervals.

In summary, the recommended use of inhaled corticosteroids is well founded not only on our knowledge of their mechanism(s) of action and the pathophysiology of the disease, but on the fact that there exists a great deal of evidence that this form of treatment can safely and dramatically change the course of asthma and alter the consequences of this common disease of children and adults.

Daniel Garcia, MD



Jan Crase

S.M.A.R.T.

HAPPY NEW YEAR! MAY 1999 BE A HEALTHY, HAPPY AND PROSPEROUS NEW YEAR FOR EACH AND EVERY PHYSICIAN WHO PRACTICES MEDICINE HERE IN THE COMMONWEALTH OF KENTUCKY.

No one could be more sincere in making those wishes for you than the Kentucky Medical Association Alliance. We look forward to working with you in the coming year in helping "fix" some of the problems existing in medicine. As you physicians continue to give quality medical care and fight for what's right for the patient, the Alliance will continue its work addressing public health education, supporting you in your legislative efforts, raising funds for medical education/research and helping you and your profession any other way that we can. By joining hands and working together, we can accomplish much in 1999. The two organizations working jointly have great potential in both talent and ability along with the necessary resources to make many positive changes in Kentucky medicine in 1999. Why don't we stir what we have?

From time to time in this column I try to inform you about some of the Alliance activities, especially those relating to public

health education projects either planned or under way. One such project being worked on now with plans for expansion in 1999 is the S.M.A.R.T. program. When we hear the work SMART, we usually think of someone being intelligent, mentally alert, bright, knowledgeable, shrewd, witty, or clever. We may think of someone being briskly efficient or perhaps stylish, elegant, or sophisticated in appearance. The SMART program, of which I speak, includes all of the good things listed above and has even another dimension.

WHAT is S.M.A.R.T.? The Alliance S.M.A.R.T. program stands for Students Made Aware Reject Tobacco. It is a tobacco prevention program for middle school students developed by our own Kentucky Alliance members Mary Gus Smith and Ginny Luftman of Fayette County. It is a frank, straightforward 45-50 minute presentation about the health and cosmetic effects of tobacco use. Upbeat and pointed slides take a look at tobacco and how it affects young people today as well as later in life. The presentation is designed to help students make an educated choice about tobacco use.

WHY is there a need for a S.M.A.R.T. program? As members of the medical family, we are all

By joining hands and working together, we can accomplish much in 1999.

The two organizations working jointly have great potential in both talent and ability along with the necessary resources to make many positive changes in Kentucky medicine in 1999.

Why don't we stir what we have?

aware of the health hazards of tobacco use and the importance of early prevention. Tobacco, however, is a very sensitive issue in Kentucky and has always been very important to our state's economy, and this is discussed in the S.M.A.R.T. program. More people per capita in Kentucky use tobacco products than any other state in our nation, consequently more people in Kentucky die from tobacco related illnesses than any other state. Our children need to be educated about tobacco just as we educate them about other harmful substances.

WHEN and WHERE is the S.M.A.R.T. program being used?

For the past two years Audrey Carter, KMAA Vice President of Health Promotions, has been teaching the S.M.A.R.T. program in Jefferson County. When Audrey started teaching this program, she had no idea how popular it would become. This past school year in Jefferson county alone, Audrey and Joyce Fletcher taught over 200 programs. The Jefferson County Health Department contacted them to teach their health educators so they could take it to even more students. The pediatric residents of Children's Hospital

and the medical students at the University of Louisville also asked to be taught the program so they in turn could teach more children. Daviess county taught approximately 75 classes in their school system this past year.

Audrey gave a workshop on the S.M.A.R.T. program at the KMAA Fall Board in September for those county presidents and others who were interested in learning more about it. Hopefully, more counties throughout the state will implement this program in '99.

As far as I know, this is the

only program of its kind and that is probably why there has been such a demand for it. If your County Medical Alliance decides to implement this S.M.A.R.T. program in your county, now that you are informed, you can be supportive in its implementation. The future health of our young people is at stake. It seems most appropriate that the KMA and KMAA assume some leadership role in Kentucky for addressing this most important public health issue.

Jan Crase
KMAA President

KMAA HONORED WITH AWARDS

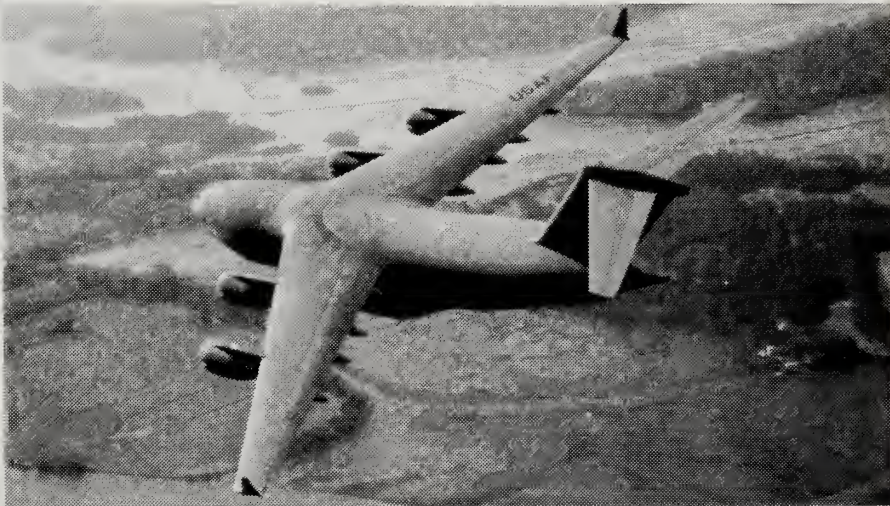
Awards won by Kentucky Medical Association Alliance at the Southern Medical Association Auxiliary annual meeting in New Orleans, November 18-22, 1998:

- Medical Heritage Award—1st place for Best Statewide Project (a documentary video on the life of Dr Louise Hutchins)
- Health Education Award—2nd place for Statewide Project (Focusing on breast cancer awareness. Teachers and staff of all Kentucky public schools were sent a reminder to get their mammograms. Also, flower seed packets, with a sticker that said, "Mammograms can detect breast cancer when it is only the size of a tiny seed," were distributed.)
- Doctor's Day Award—3rd Place for Best Statewide Project
- Health Education Award—to Pulaski County Medical Alliance for 2nd Place—Observance by County Auxiliary with fewer than 75 members (breast cancer awareness program)



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KMA BOARD OF TRUSTEES NOVEMBER MEETING

The KMA Board of Trustees met in regular session on November 18-19, 1998, at the KMA Building in Louisville. The Board members heard reports from Don R. Stephens, MD, President; William P. VonderHaar, MD, Secretary-Treasurer; John Strosnider, OD, Dean, Pikeville College of Osteopathy; Preston P. Nunnelle, MD, Kentucky Board of Medical Licensure; Robert Woods, MD, Chair, KEMPAC Board of

tee on Cardiovascular Services, chaired by Robert R. Goodin, MD, Louisville; and the Committee on Managed Care, chaired by William B. Monnig, MD, Edgewood. Kenneth R. Hauswald, MD, Ashland; Eugene H. Shively, MD, Campbellsville; and Robert C. Hughes, MD, Murray, were appointed to the KMIC Board Nominating Committee.

The Board adopted Agenda B to implement all actions of the 1998 House of Delegates. In addition, recommendations for implementation of the KMA Strategic Plan were adopted.

Reports were given by the Committees on National and State Legislative Activities, the Public Education Committee, Physician Advisory Committee to Health Kentucky, Committee on Community and Rural Health, and the KMA/KMIC joint Board Liaison Committee.

It was noted that the 1999 Annual Meeting will be held in Lexington, September 26-30.

The next meeting of the KMA Board of Trustees is scheduled for April 14-15, 1999, at the KMA Building.



Judy M. Linger, MD, Georgetown, spoke to the Board in representation of the Young Physicians Spouses.

Directors; Donald C. Barton, MD, Senior Delegate to the AMA; and Richard F. Hench, MD, Chair of the Kentucky Medical Insurance Company Board of Directors.

The Board appointed two committees, the Ad Hoc Commit-



KMA Executive Vice President William T. Applegate presented President Donald R. Stephens, MD, with a Journal cover plaque of his inaugural issue.

MARTY WHITE JOINS KMA STAFF



KMA welcomes Marshall (Marty) White to staff as Assistant Director, Public and Governmental Relations. Marty comes to us from the Kentucky Society of CPAs where he was Associate Executive Director with responsibilities relating to all facets of association management. His primary responsibilities with KMA, however, will involve the legislative and political arenas.

Marty also has served as Executive Director of Ky Forward, a non-profit political education organization dedicated to electing a more fiscally responsible legislature.

A native of Northern Kentucky and graduate of Northern Kentucky University with a Bachelor of Arts in Communication and a minor in Marketing, Marty, his wife Debbie and their two children currently reside in Frankfort.

In addition to public and government relations responsibilities, Marty is developing an extensive calendar of practice management seminars scheduled from February to July. Look for the release of that schedule in the February edition of the *Journal*. Sign up for one of the seminars, meet Marty there, and join us in welcoming him to KMA.

NEWSMAKERS

William B. Lockwood, MD, traveled to the People's Republic of China to sign an agreement with the Shanghai Blood Center, making the two centers "sister blood banks." Dr Lockwood has been medical director of the River Valley Region Blood Services in Louisville since 1988.

Bob M. DeWeese, MD, has been recognized by the University of Louisville Alumni Association for an Alumni Fellows Award. A retired surgeon and past president of KMA, Dr DeWeese was elected to the House of Representatives for Kentucky's 48th District in 1992.

Lowell D. Katz, MD, was installed as international president of the Phi Delta Epsilon Medical Fraternity at the fraternity's 94th annual convention and scientific meeting. Dr Katz is with Louisville Colorectal Associates, PLLC.

David E. Bybee, MD, FACP, and **Charles E. Dobbs, MD, FACP**, have each been honored with a Kentucky Chapter Laureate Award from the American College of Physicians—American Society of Internal Medicine. Dr Bybee is a Louisville endocrinologist who earned this award for his commitment to the profession of medicine and to the process of its improvement. Dr Dobbs, who has served as state president of the American Cancer Society, is board certified in internal medicine, hematology, and

medical oncology. Practicing in Louisville, he was honored for his distinguished career and dedication to internal medicine.

Richard S. Wolf, MD, received the 1998 Ephraim McDowell Physician of the Year Award presented by the Caritas Foundation at the 3rd annual Doctor's Ball. This award honors a physician who makes significant contributions to medicine, demonstrates humanitarian service, and represents the medical profession with high distinction.

Dr Wolf's medical career spanned more than four decades. Although now retired, Dr Wolf was the medical director of Kosair Children's Hospital and in private practice for more than 30 years. Kosair also established the Richard S. Wolf Instructorship Fund to underwrite the salary of Kosair Children's Hospital's chief resident in perpetuity.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

BOYD

Robert Hollis Jr MD *FP*
2211 Montgomery Ave
Ashland 41101
1984, U Cincinnati

FAYETTE

Terre W Adams MD *IM*
1221 S Broadway
Lexington 40504
1986, Texas Tech

Susanne M Arnold MD *HEM*
336 Henry Clay Blvd
Lexington 40502
1992, U Kentucky

William R Crowe MD *U*
1760 Nicholasville Rd
Lexington 40503
1993, U Kentucky

Willem J S De Villiers MD *GE*
UKMC, Dept Internal Medicine
Lexington 40536-0084
1983, U Stellenbosch, S Africa

Lisa T DeGnore MD *ORS*
1780 Nicholasville Rd Ste 501
Lexington 40503
1986, U Michigan

David P Dubocq MD *FP*
4033 Palomar Blvd
Lexington 40513
1984, State U New York, Brooklyn

Jennifer A Fuson MD *OBG*
2620 Wilhite Dr
Lexington 40503
1994, U Kentucky

Jens Goebel MD *PD*
3624 Burning Tree Lane
Lexington 40509-1932
1989, Heidelberg U, Germany

Daniel T Goulson MD *AN*
168 Eastover Dr
Lexington 40502
1989, U N Carolina

Sibel S Gullo MD *IM*
1221 S Broadway
Lexington 40504
1993, Wright State U, Ohio

Dermot P Halpin MD *TS*
1401 Harrodsburg Rd Ste C 100
Lexington 40504-3701
1988, Trinity Col, Ireland

Dennis R King MD *FP*
1782 Bryan Station Rd
Lexington 40505
1986, UTESA, Dominican

Republic
David S Kim MD *PS*
940 Cherrywood Dr
Lexington 40515-5021
1992, U Kentucky

- Jon K Kostelic MD** *R*
1725 Harrodsburg Rd Ste F1
Lexington 40504-3675
1991, Med Col Wisconsin
- W. Travis Lawson Jr MD** *IM*
Ky Clinic North 234 E 3rd St
Lexington 40508
1981, U California, Davis
- Anthony Marano MD** *C*
2272 Savannah Ln
Lexington 40513
1991, U Virginia
- Hamid R Mohanmadzadeh MD TS**
1401 Harrodsburg Rd Ste C100
Lexington 40504-3701
1991, Temple U, Pennsylvania
- Ronald L Newman DO** *AN*
2244 Belmont Dr
Lexington 40516
1990, U Health Sciences, Missouri
- Keith Randall Parker MD** *R*
1221 S Broadway
Lexington 40504
1988, U Tennessee
- Mark Brendan Reedy MD** *OBG*
UKMC OB/GYN MN 306 0084
Lexington 40536-0084
1989, Texas Tech
- Jeffrey L Wilson MD** *OTO*
1221 S Broadway
Lexington 40504
1989, U Kentucky
- Bradley B Youkilis MD** *OBG*
2620 Wilhite Dr
Lexington 40503
1991, U Cincinnati
- FLOYD**
- James A Campbell DO** *IM*
686 Riverside Dr
Prestonsburg 41653
1994, W Va School Osteopathic Med
- HART**
- Richard P Ribeyre MD** *FP*
207 E Main St
Horse Cave 42749
1995, U British Columbia
- HENDERSON**
- William G Marshall, Jr MD** *TS*
2000 N Elm St Bldg 1A
Henderson 42420
1977, U Kentucky
- HOPKINS**
- William J Crump MD** *FP*
435 N Kentucky Ave Ste A
Madisonville 42431
1979, Vanderbilt, Tennessee
- JEFFERSON**
- J Khristen Basham MD** *OBG*
2003 Emerson Ave
Louisville 40205
1993, U Louisville
- Herbert H Boyd MD** *OBG*
210 E Gray St Ste 802
Louisville 40202
1994, U Louisville
- Luyen V Cao MD** *IM*
3025 Stonebridge Rd
Louisville 40241
1985, Rush, Illinois
- Cheryl G Cowens MD** *AN*
6200 Dutchmans Lane Ste 207
Louisville 40205
1991, U Louisville
- John M DeMaio MD** *AN*
4001 Dutchmans Ln Ste 4-B
Louisville 40207-4736
1988, Royal Col Surgeons, Ireland
- Timothy H Gregg MD** *AN*
3532 Ephraim McDowell Dr
Louisville 40205-3224
1978, U Louisville
- Michael G Holthouser MD** *PMR*
9420 Felsmere Cir
Louisville 40241-4412
1971, U Kentucky
- Michael J Moskal MD** *ORS*
225 Abraham Flexner Ste 700
Louisville 40202
1990, U Illinois, Chicago
- James P Moss MD** *S*
3617 Glenview Ave
Glenview 40025
1966, U Louisville
- Helmut R Roehrig PhD**
3 Audubon Medical Plaza Ste L-10
Louisville 40217
1992, Xavier U, Columbia
- Carole B Scharf MD** *ONC*
801 Barret Ave Ste 106
Louisville 40204
1993, U Louisville
- Maria R Schweichler MD** *OBG*
2245 Lowell Ave
Louisville 40205
1994, Brown U, Rhode Island
- Mourhaf Traboulssi MD** *C*
550 S Jackson St 3rd Floor
Louisville 40292
1983, Damascus U, Syria
- Daniel M Tucker MD** *P*
2169 Emerson Ave
Louisville 40205
1975, U Florida, Gainesville
- LINCOLN**
- Robert M Gevedon MD** *EM*
1237 Birmingham Lane
Lexington 40513
1992, U Texas, Galveston
- MCCRACKEN**
- Mark G Weissinger MD** *OBG*
2311 Kentucky Ave
Paducah 42003
1990, State U S Dakota
- WARREN**
- Joseph C Gass MD** *OBG*
369 Deer Meadow Ave
Bowling Green 42103
1987, U Tennessee
- IN-TRAINING**
- FAYETTE**
- Shilpi Chahra MD** *PD*
Marta Hayne MD *R*

JEFFERSON

Cameron W Cole MD *PD*
William J Housworth MD *IM*
John S Koch MD *R*
Steven D Skaggs MD *EM*

OBITUARIES

John C. Burris, MD
Paducah
1927-1998

John C. Burris, MD, a radiologist, died June 29, 1998. Dr Burris graduated from the University of Louisville School of Medicine in 1956 and was an active member of KMA.

Byron W. Hill, MD
Henderson
1939-1998

Byron W. Hill, MD, a general surgeon, died October 1, 1998. A 1967 graduate of the University of Saskatchewan, Dr Hill was an active member of KMA.

Elbert L. Dennis, MD
Louisville
1917-1998

Elbert L. Dennis, MD, a retired general surgeon, died October 13, 1998. Dr Dennis was a 1942 graduate of the University of Louisville School of Medicine and a life member of KMA.

Betty S. Wheeler, MD
Lexington
1925-1998

Betty S. Wheeler, MD, a retired general practitioner, died October 16, 1998. A 1951 graduate of the University of Louisville School of Medicine, Dr Wheeler was a life member of KMA.

Okey H. Sanford, MD
Flatwoods
1932-1998

Okey H. Sanford, MD, a retired family practitioner, died October 16, 1998. Dr Sanford was a 1963 graduate of West Virginia University School of Medicine and a life member of KMA.

Thomas D. Brower, MD
Lexington
1924-1998

Thomas D. Brower, MD, a retired orthopedic surgeon, died November 16, 1998. A 1947 graduate of Washington University School of Medicine, Dr Brower was former chief of the University of Kentucky Medical Center's division of orthopaedic surgery. He was a life member of KMA.



**A is for Apple,
B is for Ball,
C is for Cancer.
Cancer?**

Although only 3, Adam knows all about a very grown-up disease. He's got cancer.

Fortunately, he also has *St. Jude Children's Research Hospital*, where doctors and scientists are making progress on his disease. To learn how you can help St. Jude in its life-saving work, call: **1-800-877-5833**.



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Danny Thomas, Founder

Cancer Self-Study Kit Offers Free CME Credit

The Kentucky Cancer Program is introducing **Providers Practice Prevention**, a free new self-study kit for physicians to increase routine breast and cervical cancer screening among Kentucky women. The kit includes office reminder tools and a video which discusses existing patient barriers, explores screening controversies and provides discussion techniques for use with patients for cancer screening.

Funded by Centers for Disease Control and Prevention through the Kentucky Department of Public Health, the project is endorsed by KMA, KAHP, UL and UK medical schools, KY Section-ACOG, KY Society of Pathologists, American Cancer Society, and other associations. The Kentucky Medical Insurance Company will offer a malpractice insurance premium reduction on completion of the kit.

The self-study kit was planned and produced in accordance with ACCME Essentials and Standards. The Kentucky Medical Association is accredited by the ACCME to sponsor continuing medical education for physicians. KMA designates this continuing medical education activity as meeting the criteria for two (2) hours in Category 1 credit towards the AMA Physicians Recognition Award.

Contact the Kentucky Cancer Program 502/852.6318 or 1-800/334.8635, ext 6318, to order a kit.

Alert on Billing Service Companies

Do you use a billing company for your office? Keep in mind that you are responsible for the billings generated by that company. Several emergency room staffing companies learned that the hard way when they were forced to pay over \$8 million allegedly resulting from false claims being submitted through an Oklahoma City billing company known as Emergency Physician Billing Services (EPBS). The settlements were a result of information supplied to the government by a former employee of EPBS.

Is Your Office Y2K Compliant?

AMA Trustee Donald J. Palmisano, MD, reported to a special Senate Committee that: "The Year 2000 problem will affect virtually all aspects of physicians' practices—especially patient care. There are real risks that need to be anticipated and corrected." Some of the areas cited include:

- Patient scheduling
- Budgets
- Insurance policies expiring after 2000
- Patients' birthdates
- HCFA even warns that an interruption in medical claims processing because of non-compliant systems is going to be considered a performance error.

In an effort to educate physicians, the AMA will hold a series of regional Year 2000 (Y2K) seminars for physicians and has set up a Y2K section on its web site (<http://www.ama-assn.org/not-mo/y2k/index.htm>) with regularly updated information. Contact the AMA if you would like additional information or dates and locations of the seminars.

Academy urges 'Sign Your Site' to eliminate wrong-site surgery

The American Academy of Orthopaedic Surgeons has launched "Sign Your Site," a national education program to encourage surgeons in all medical specialties, other health care providers, and hospital officials to implement effective controls to eliminate wrong-site surgery.

The Academy's Advisory Statement on Wrong-Site Surgery recommends the operating surgeon discuss the surgery with the patient before anesthesia, place his/her initials on the operative site using a permanent marking pen, and then operate through or adjacent to his/her initials. The Advisory Statement also includes recommendations for specific actions to be followed if the surgeon discovers that he or she is performing or has performed wrong-site surgery.

A copy of the Advisory Statement on Wrong-Site Surgery can be obtained by calling Emily Kattke at the Academy, 847/384.4126. The Advisory Statement also is in the "Library"

section of the Academy's home page www.aaos.org and fax-on-demand 800/999.2939, document number 1015.

Parents' touch plays role in helping preemies

Premature babies are hooked up to banks of medical equipment in their fight for survival. University of Louisville researchers have added to the arsenal a low-tech weapon—a parent's touch.

Neonatologist **Dan L. Stewart, MD**, says some patients practice Kangaroo Care, a technique that got its name because it resembles the way a kangaroo carries its young in its pouch. Parents hold the baby against their bare chest to promote skin-to-skin contact. Immediate results include an apparent calming effect, greater weight gain, and shorter hospital stays; long-term benefits include improved parent-child bonding.

Many medical professionals have been leery of Kangaroo Care because of a theoretical increased risk of infection. Dr Stewart says such a risk has not been documented.

Lasers help angina patients heal themselves

According to information from the University of Louisville, heart surgeons are bypassing traditional open-chest procedures to treat some forms of angina. Instead, they are using a non-invasive procedure that relies on lasers

and the body's ability to take care of itself.

Cardiologist **Ronald R. Masden, MD**, uses a laser to bore hundreds of tiny holes into the heart. The heart responds by developing new blood vessels that increase blood flow to weakened areas of the heart.

Performed with local anesthetic, the operation is less painful and requires a much smaller incision than open-heart surgery. Patients run a lower risk of infection and usually recover in shorter time, often going home in a day or two instead of open heart surgery's five-day minimum recuperative period.

American Head and Neck Society

The American Society of Head and Neck Surgery and The Society of Head and Neck Surgeons have announced that they joined together to form the **American Head and Neck Society (AHNS)**, the single largest organization in North America that will provide a single voice to the advancement of research and education in head and neck oncology.

According to the announcement, the new medical society's mission is to promote and advance the knowledge of prevention, diagnosis, treatment and rehabilitation of neoplasms and other diseases of the head and neck, to promote and advance research in diseases of the head and neck, and to promote and advance the highest professional and ethical standards. Addition-

ally, the American Head and Neck Society will facilitate the direction of resources for head and neck oncology research and education into the 21st century.

For more information, please contact the American Head and Neck Society's office at 203 Lothrop Street, Suite 519, Pittsburgh, PA 15213, phone 412/647.2227 or fax 412/647.8944.

Scientists survey stats for keys to improved breast cancer prognoses

Breast cancer patients have a better chance of survival today than ever before, according to a study by University of Louisville and National Institutes of Health researchers.

Michael J. Edwards, MD, and **John W. Gamel, MD**, of U of L and Eric Feuer of NIH studied 30 years of breast cancer data to find out why women diagnosed with breast cancer have a better prognosis now than in the past. Women diagnosed with breast cancer in 1965 had essentially the same prognosis as women in 1984—as long as the cancer had not invaded the lymph nodes.

In women whose cancer had spread to lymph nodes, however, the prognosis was markedly better in 1984 than in 1965. Women later in the study tended to live longer and more of them were cured.

U of L Hospital's Level I Trauma Unit

Major improvements to University of Louisville Hospital's Level I Trauma Unit have more than doubled its capacity and capability to provide the latest in emergency patient care.

The renovation increased the size of the emergency medicine unit to 56,000 square feet—up from 21,000. The number of treatment areas has grown from 27 to 43; two major resuscitation rooms, three post-resuscitation rooms, and four emergency treatment areas also were added.

"Coming from New York and dealing with some major trauma incidents, they would have given anything for an emergency facility like we have here now," said **Joel A. Kaplan, MD**, vice president for health affairs.

The facility contains both patient treatment areas and faculty and staff offices for U of L's emergency medicine department.

The facility also boasts the state's only hazardous materials decontamination unit attached to a trauma center equipped to handle major trauma emergencies.

The area also has several negative pressure rooms which have their own ventilation systems to reduce the risk of spreading airborne diseases.

Expanded emergency facilities also allow the university to enhance its educational and research opportunities, said Dr Kaplan, who also is dean of the medical school.

Anesthesiologist Goes to Source of Back Pain

According to a recent report, a University of Louisville anesthesiologist has found success in treating chronic back pain by going directly to the source.

Using a flexible endoscope to find and treat pain right in the spinal canal, **Michael G. Cassaro, MD**, associate professor of anesthesiology and director of U of L's Pain Management Clinic, has been able to relieve chronic lower back pain in a significant number of his patients.

The procedure involves inserting a flexible fiber-optic endoscope into the spinal canal at about the tailbone level, then threading it up the canal until Dr Cassaro, with the help of his patient, locates the painful area.

The patient is awake during the procedure and can alert Dr Cassaro to pressure points that harbor painful scar tissue.

The endoscope allows Dr Cassaro to examine the spinal canal and its contents, diagnose what may be causing the pain and render treatment.

In many cases, the scope itself can be used as a "blunt probe," breaking up small bands of scar tissue that form and irritate the nerve roots and cause pain and inflammation. Once the scar tissue is cleared away, Dr Cassaro administers an anti-inflammatory medication to the site through the scope.

Dr Cassaro believes the scope is a superior diagnostic

tool because it gives a three-dimensional, color view in a real-time video display, and it picks up abnormalities in the spinal canal that are too small to be detected by Magnetic Resonance Imaging (MRI), with its two-dimensional, shades-of-gray display.

"Usually, the reason injected medications don't work properly is that the medication never gets to the areas they need to get to. With this scope, the areas where pain is generated can be visually identified and then the medications can be injected directly into that area," he said.

Dr Cassaro says the procedure is not for everyone, but has been effective for some patients who suffer from chronic back pain that radiates to the legs and for whom other therapies and surgeries have failed.

The endoscopic procedure can be performed on an outpatient basis, with the patient going home an hour or two after the procedure. It involves only a couple of stitches to close up the incision site.

The report states that after the procedure, about 40% of Dr Cassaro's patients get long-term pain relief—6 months or more; another 40% get relief for a shorter time—less than 6 months; and 20% experience little or no significant improvement.

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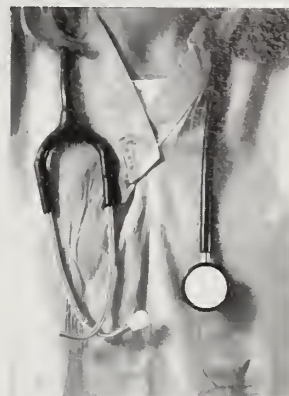
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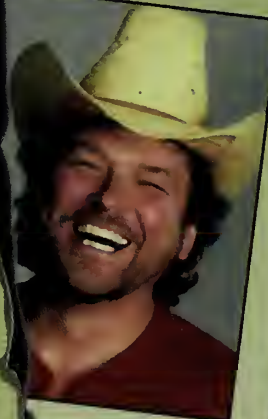
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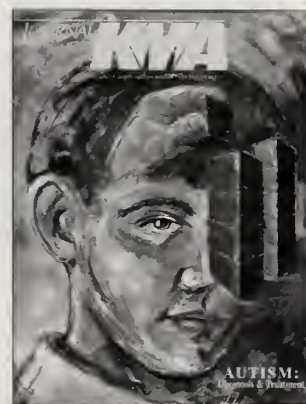
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Autism is a relatively common developmental disorder characterized by pervasive impairments in communication and social interaction as well as restricted interests and repetitive behaviors. This month's cover story presents two case reports to illustrate important aspects of diagnosis and treatment.

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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Periodical postage paid at Louisville, KY and additional offices. Yearly subscription rates: \$35 domestic; \$45 foreign. Single issues \$4 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222. Telephone 502/426-6200; Fax 502/426-6877.

Listed in *Index Medicus*. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

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RESPONSIBILITY



As physicians we are expected to live up to our responsibilities and bear our burdens. If we do not, we forfeit our right to complain.

Webster's Collegiate Dictionary defines responsibility as the quality or state of being responsible as a moral, legal, or mental accountability, reliability, trustworthiness and something for which one is responsible, a burden.

As physicians, we have many responsibilities in addition to our responsibilities as parents, spouses, and citizens. Our education and various specialized training gives us responsibility for:

- a. health and well being of our patients
- b. prevention of disease and suffering
- c. establishment and preservation of a health care system
- d. preservation of the practice of medicine
- e. teaching our arts and sciences to others.

Many of you may disagree that establishment and preservation of a health care system is not our responsibility. If not, to whom should we relinquish this responsibility? Congress, consumers, governors, state legislatures, the courts? I believe these experiments have already been tried and have failed or are failing. The system that we experience daily others only experience when in need. We know what tests are necessary, when admission is required and when there is little use to expend further efforts; but I don't have to convince you who knows the best way to practice medicine. Part of our responsibility is convincing governing authorities that we are not "foxes in the hen house" as Mrs Clinton implied, but guardians of health and our health care system.

Often when I approach physicians to be delegates, serve on committees or help with a campaign, the answer I receive is that "I just don't have time." When an event adverse to medicine occurs, many of these physicians are the loudest and longest complainers in the doctors' lounge. As physicians we are expected to live up to our responsibilities and

bear our burdens. If we do not, we forfeit our right to complain.

How can we face the responsibilities, bear these burdens?

As always burdens that are shared are more easily carried. Organized medicine is the vehicle which we can use to carry our burdens and convince others of our motives and message regarding health care reform.

Every physician can afford the dues and the time to attend local meetings—by building and rebuilding strong grassroots support messages that can easily be sent to the top (governing authorities).

We can be consistent with our message through county societies, the KMA, and the AMA. KEMPAC and AMPAC support by all will demonstrate we are able to put our money where our mouth is. I would be much more impressed if all physicians were members of the KMA and AMA and each gave \$100 to KEMPAC. Then our opinion would be magnified and we would be able to project our ideas and have more impact into the system. This would give us real *Responsibility*.

If our forefathers had been too busy or indifferent to their beliefs, we would not be able to vote or experience the wonderful degree of freedom we have today. Let us remember their great sacrifices for our benefit when we are asked to make a small sacrifice of time or money to fulfill our responsibilities.

Harry W. Carloss, MD
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Few Surprises in Organizational Session

Unlike the 1997 organizational session when Senator Larry Saunders (D, Louisville) worked with Mountain Region Democrats and Republicans to oust then President of the Senate John "Eck" Rose, the 1999 organizational session held few surprises. In fact, the only shake-up that drew attention this year was Senator David Williams' (R, Burkesville) election to Minority Floor Leader.

Senator Williams decided to run for the Republican Party's top spot in the Senate when Senator Dan Kelly (R, Springfield) indicated shortly before the organizational session that he would not seek re-election to the leadership post he held for several years. Under Senator Williams' leadership, many believe the Senate Minority is more likely to advocate traditional party lines of fiscal responsibility and less government.

Other changes in Senate leadership include Senator Walter Blevins (D, West Liberty), who was President Pro Tem in 1997-98, became Majority Whip replacing retiring Senator Fred Bradley. Senator Joey Pendleton (D, Hopkinsville) was elected President Pro Tem, and Senator Gary Johnson (D, Pikeville) replaced retiring Senator and physician Nicholas Kafoglis, MD, as Majority Caucus Chair. Senator Charlie Borders (R, Russell) was elected Minority Caucus Chair in place of Senator Dick Roeding (R, Ft Mitchell).

In the House of Representatives, the only big story was the race that wasn't. Weeks before the organizational session, Representative Pete Worthington (D, Washington) flirted with the idea of running against Majority Floor Leader Representative Greg Stumbo (D, Prestonsburg). Before the session started, he decided against it when he determined the votes were not there. On the Minority side of the aisle, Representative Stan Cave (R, Lexington) did not seek re-election as Minority Caucus Chair, allowing 1997-98 newcomer to the legislature Representative Jeffrey Hoover (R, Jamestown) to fill that vacancy.

MONITORING **Medicine**

DeWeese Named Vice Chair— Twice

While his appointment as Vice Chair of the Health & Welfare Committee was expected, the appointment of Representative Bob M. DeWeese, MD (R, Louisville) as Vice Chair to the influential Appropriations & Revenue Committee was a pleasant surprise to the medical community and many legislators. Serving in the House of Representatives since 1994, Representative DeWeese has brought a sound sense of fiscal responsibility to the legislature, earning him the post as Vice Chair of A & R.

As far as his participation on the Health & Welfare Committee is concerned, Dr DeWeese has represented patients' and the medical community's interest well. You may recall from the 1998 regular session of the General Assembly that he was a co-author of House Bill 315, which provides many of the patient protection measures Kentucky citizens benefit from today. As Vice Chair of Health and Welfare, Representative DeWeese is likely to continue his support of patient protection provisions in Kentucky's laws.

Legislative Briefing Provides Status of HB315

During the 1999 organizational session, legislative briefings were conducted primarily for the benefit of new legislators who may not be familiar with all of the issues the General Assembly considers. The briefing that drew the most interest from legislators and lobbyists was Commissioner of Insurance George Nichols' briefing on the status of House Bill 315.

A patient protection provision of HB 315 addressed by Commissioner Nichols was "guaranteed issue," which provides every Kentucky citizen access to health insurance. To implement "guaranteed issue" provisions, the "Guaranteed Acceptance Program" of GAP was established to reimburse carriers for losses incurred through insuring certain individuals defined as high cost. Although GAP was established to offset losses, carriers and many legislators draw attention to "guaranteed issue" claiming the provision is a primary driver of increasing health insurance premiums.

During his briefing, Commissioner Nichols was asked about repealing the "guaranteed issue" provision of HB 315 and what effect that would have on

rising insurance costs. In response, Nichols said "guaranteed issue" is only a piece of the puzzle and that rising insurance premiums are the result of many factors — not the least of which is the legislature's passage of House Bill 250 in 1994. Many claim Kentucky's attempt to reform health care in 1994 drove carriers out of the Kentucky market. Nichols went on to say that he was in favor of legislation that provided every citizen of the Commonwealth with the opportunity to purchase health insurance.

In addition, the Commissioner said it is unlikely Kentuckians can look forward to insurance premiums going down in the near future. He attributed this comment to the increasing costs associated with providing quality health care and, more importantly, the recent struggles of the legislature to tackle this complex issue. Nichols also indicated the legislature should stay the course with House Bill 315 and encourage more carriers to reenter the Kentucky insurance market, thereby fostering competition. At this time, four carriers have indicated interest in reentering the Kentucky market.

MONITORING **Medicine**

Medicaid Partnerships Stalled

To receive a copy of Commissioner Nichols' report about the status of House Bill 315 or chronology of health insurance legislation events since 1992, please contact KMA by phone at 502/426.6200 or e-mail to white@kyma.org.

At another legislative briefing for the 1999 organizational session, Secretary for Health Services John Morse and his staff provided an update of the Medicaid Managed Care Partnerships Program. To date, only two of the eight partnerships are operational — Region 3, the Louisville/Jefferson County area, and Region 5, the Lexington/Fayette County area. Other than those two, the development of the remaining six regions seems to have slowed.

The following is the status of the other regions as reported by Dennis Boyd, Commissioner of Medicaid, and a recent article in the *Harkey Report*:

- Region 1 — far west Kentucky has formed a new non-profit corporation but can't decide what risk-bearing entity to use. The region has less than 25,000 enrollees and may pool resources with Region 2 to form a single partnership.
- Region 2 — Owensboro, Henderson, Hopkinsville area is seeking financial commit-

ment from its partners and as stated above is encouraged to combine with Region 1.

- Region 4 — south central Kentucky is waiting to hear from the Kentucky Hospital Association about assistance on an ASO and may split and combine resources with Regions 3 and 5.
- Region 6 — northern Kentucky withdrew individual application and is partnering with Region 7 because, like Region 1, it has less than 25,000 enrollees.
- Region 7 — eastern Kentucky (see explanation above).
- Region 8 — southeast Kentucky, the region with the most enrollees in the state, may need as much as \$8 million in start-up capital that officials will not likely loan because of Federal guidelines. The region also has two competing provider entities for the contract.

For more information, please contact KMA by phone at 502/426.6200 or e-mail at padgett@kyma.org.

CASE REPORTS IN AUTISM: ISSUES IN DIAGNOSIS AND TREATMENT

Patricia Gail Williams, MD; Allan S. Bloom, PhD

Autism is a relatively common developmental disorder characterized by pervasive impairments in communication and social interaction as well as restricted interests and repetitive behaviors. Two case reports are presented to illustrate important aspects of diagnosis and treatment. Early clinical diagnosis is essential so that appropriate intervention can be implemented. A multidisciplinary approach to treatment is recommended due to the impact of autism on many aspects of behavior and development.

Two recent surveys of primary care physicians in the state of Kentucky were conducted by the Child Evaluation Center. A 1992 survey was aimed at exploring the availability of community-based services for persons with developmental disabilities. Sixty-one percent of a random sample of primary care physicians returned surveys. Eighty percent of respondents indicated that they required more information about community resources and 70% felt that they were deficient in their understanding of psychological and psychosocial aspects of developmental disorders. A 1998 survey addressed primary care issues in the treatment of children with autism. Eighty-nine percent of respondents reported having at least one child with autism in their practice. Physicians indicated that they were frequently asked by parents of these autistic children about behavioral and developmental issues. Ninety percent of those who returned surveys indicated that it would be helpful to have access to information which might facilitate office visits for children

with autism. Such surveys serve to document that physicians wish additional information on developmental disabilities such as autism.

The term autism was first used by Dr Leo Kanner in 1943 to describe a pattern of development and behavior in 10 children seen in his psychiatric practice.¹ Autism is not a rare disorder, as was once thought. Current estimates of its prevalence are 1:1000.² Therefore, it is likely that primary care physicians will see individuals with this disorder in their practice. Autism has come to be recognized as a spectrum disorder with considerable variation in presentation based on such factors as cognitive abilities. Despite this variability, some characteristic patterns of behavior are often seen at an early age. In this paper two brief case reports are presented to illustrate some of the issues regarding identification and management of children with autism.

Case Report 1

J.L. is a 2 year 7 month old male who was referred for evaluation secondary to speech and language delay. Birth history revealed that J.L. was the second pregnancy for his then 20 year old mother. He was delivered vaginally following an uncomplicated gestation with a birth weight of 8 pounds, 8½ ounces, and length of 21 inches. Past medical history was unremarkable. Developmental history indicated that J.L. sat alone at 5 months of age and walked at 8 months. He is not currently toilet trained. He finger feeds but does not yet use a spoon. He said his first words at 9 to 12 months of age, but stopped talking between 18 months and 2 years. Communication consists primarily of pulling his parents by the hand toward a desired object. He does not point or gesture but vocalizes. Behaviorally, J.L. is described as being "in a world of his own." He loves watching Disney movies and listening to music. He stacks cans and shuts doors repetitively. He tends to ignore others for the most part and may laugh for no apparent reason. He sometimes flaps his hands and watches his fingers as he moves them in front of his face. Family history was remark-

able only for several paternal family members who were described as being loners and uninterested in socialization.

Physical examination revealed a well developed 2 year old with growth parameters between the 25th and 75th percentile for age. Overall physical examination was within normal limits. Neurologic examination revealed intact cranial nerves with adequate muscle strength and diminished muscle tone. Deep tendon reflexes were symmetric. There was no well established hand dominance.

Following psychological, speech and language, and neurodevelopmental evaluations, J.L. was diagnosed with autism. Brainstem Auditory Evoked Response testing was consistent with normal hearing bilaterally. Additional tests were recommended including sleep-deprived EEG, fragile X DNA testing, chromosome analysis, urine metabolic screen, thyroid function tests, and lead level. J.L. was referred for speech and language and occupational therapy services through Kentucky's Early Intervention System. In addition, it was recommended that he be enrolled in a structured preschool program. J.L.'s parents were encouraged to pursue consultation with a behavioral specialist in autism and were referred to local resources in autism. Follow up evaluation was recommended in one year to better determine cognitive functioning, progress, and interventional needs.

Case Report 2

J.G. is a 6½ year old male who was seen for follow up evaluation. J.G. was initially diagnosed with autism in May 1995. His past medical history is significant for congenital hydrocephalus identified on fetal ultrasound at 26 weeks gestation. Amniocentesis revealed a normal male karyotype. J.G. was delivered at 29 weeks and required a prolonged stay in the neonatal intensive care unit with ventriculo-peritoneal shunt placement at 4 weeks of age. J.G. has had several shunt revisions. Medical history is also significant for inguinal hernia repair, chronic otitis

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media requiring bilateral myringotomy tubes, and surgery for strabismus in the right eye. Hearing was recently retested and was normal. Appetite is good and sleep is not problematic.

Developmental history revealed that J.G. walked at 3 years of age and has just recently started to run. He climbs up stairs nonreciprocally and is able to throw a ball. He has difficulty feeding himself with a spoon, but assists with dressing. He uses short sentences to express basic wants and needs. He tends to refer to himself in the third person and frequently uses stereotypic utterances. He is currently enrolled in a regular first grade program within the public school system and receives special education services several hours daily. He also receives occupational therapy and speech and language therapy services through the public school system.

Behaviorally, J.G. likes to engage in largely solitary activities such as watching news programs, golf programs, Barney, and cooking shows on television. He is currently fascinated with golf, cooking, and Kentucky basketball. He tends to look at the same books over and over again. He has difficulty transitioning from one activity to another. He interacts to some extent with adults but rarely with children his own age. When excited he flaps his hands and makes somewhat unusual noises. He is sensitive to sounds such as a baby crying as well as to textures and refuses to place his hands in Play-Doh, rice, and shaving cream. J.G. has presented with increasing behavioral problems. Over the past 2 years he has begun pinching others and banging his head when upset.

On physical examination J.G.'s height was at the 25th percentile with weight at the 90th percentile and head circumference above the 95th percentile. Overall physical examination was within normal limits. Neurologically, J.G. had a right hand preference with somewhat decreased muscle tone and a wide-based, flat footed gait. Deep tendon reflexes were symmetric. J.G. was generally cooperative, but at times appeared quite anxious and attempted to pinch the examiner. Psychological evaluation yielded an I.Q. score of 64 on the Leiter

International Performance Scale with achievement scores on the Kaufman Assessment Battery for Children ranging from 62 in arithmetic to 91 in reading. Speech and language evaluation indicated a communication disorder with most receptive and expressive language skills between 2 and 2½ years of age. Occupational therapy evaluation indicated fine motor abilities at a 24 month level with significant sensory regulatory problems. Based on evaluation results, specific recommendations were made for J.G.'s educational program including use of extensive visual cues to assist in transitions as well as augmentative communication techniques to supplement speech. Ongoing consultation with behavioral specialists in autism was recommended as well as consideration of a trial of a Selective Serotonin Reuptake Inhibitor to address anxiety, sensory difficulties, and insistence on rituals.

DISCUSSION

These two cases demonstrate some of the salient features of autism. Autism is identified four times more commonly in males than females. While the specific etiology for autism is unknown, its neurobiologic nature is well established.³ Features which support a neurobiologic basis include increased frequency of seizures in individuals with autism; mental retardation in 50 to 70% of individuals; evidence of genetic predisposition with recurrence risk of 3 to 7%; and associated sensorimotor deficits (eg, hypotonia, toe walking, motor stereotypies and sensory integration difficulties).¹ Autism has been recognized in association with a variety of other medical and genetic conditions including fragile X syndrome, tuberous sclerosis, metabolic disorders, fetal rubella syndrome, hemophilus influenza, meningitis, and structural brain abnormalities.³ It is currently estimated that 10% of cases of autism may be linked to a known medical condition affecting Central Nervous System development.^{4,5}

Many children with autism are first diagnosed between the ages of 2 and 4 years.

Clinical diagnosis is based on DSM-IV criteria, and involves pervasive deficits in communication and social interaction as well as markedly restricted range of interests with repetitive and stereotyped behaviors.⁶ Speech and language delay is often the primary concern for families bringing children for evaluation.⁷ Unlike children with communication disorders related to hearing impairment or motor speech problems, children with autism have difficulty compensating through alternative modes of communication such as gesture. Efforts to communicate wants and needs are often vague and consist primarily of leading a parent by the hand to the vicinity of the object. Some children, particularly those who are lower functioning cognitively, remain essentially nonverbal. Others develop speech but exhibit marked impairments in their ability to initiate and sustain conversation with others. They may engage in stereotyped and repetitive use of language (eg, repeating phrases spoken by others or heard on television), or exhibit pronominal reversal (eg, mixing up "you" and "I").

While communication problems are often the chief complaint, the underlying core deficit in autism is believed to be in social behavior. This deficit is probably most evident in the child's failure to develop normal peer relationships. Interest in other children is diminished with decreased social responsiveness to the approach of other children. This aloofness and self-occupying behavior is usually prominent in the day care or preschool setting. It is important to note that with familiar adults, short periods of more normalized social interaction can be structured so that social difficulties may not be as obvious in brief visits to the physician's office.

Restricted, repetitive, and stereotyped behavior often represents what is most observedly abnormal in autism. Children demonstrate only limited functional play. They may line up toys by color or category. There may be unusual pre-occupations with objects (traffic lights, vacuum cleaners), or unusually intense interests (meteorology, dinosaurs). Unusual sensory interests are common, and may include smelling toys or people inappropriately, or staring at moving

objects. This category also incorporates compulsive behavior and stereotypical movements.

Increasingly the importance of early identification of autistic children has been recognized. Of interest to primary care physicians is the development of the Checklist for Autism in Toddlers (CHAT).^{8,9} This brief list of questions to parents and observations by the primary care physicians has been used in Britain with 18 month olds during routine office visits. The checklist pinpoints three specific behaviors (protodeclarative pointing, gaze monitoring, and pretend play) which are typically absent in children with autism at this age. This screening instrument appears to have good specificity and sensitivity and shows promise as a tool for early identification.

Once a child has been referred for evaluation, diagnosis is based on detailed history and clinical observation with frequent use being made of semistructured parent interviews and observational schema for clinic and school settings. Assessment for intervention purposes frequently requires a multidisciplinary approach. Psychological evaluation is important to establish current level of cognitive and adaptive functioning and frequently necessitates use of a nonverbal intelligence test in view of the child's significant language deficits. Speech and language evaluation is indicated to suggest strategies for establishing a functional communication system. An occupational therapy evaluation is helpful in addressing sensory integration problems and difficulties with fine and visual motor skills. Medical evaluation should include a comprehensive medical history with attention to pregnancy and delivery, chronic illnesses, eating and sleeping patterns, and family history.

Physical examination should give special attention to growth parameters, skin findings, and dysmorphic features which might suggest an associated medical condition. Neurologic examination frequently reveals subtle neurologic findings such as mild hypotonia, persistent toe walking, and late establishment of hand dominance. An audiologic evaluation is essential to rule out hearing loss. Additional diagnostic workup which may be considered based

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on history and physical examination includes chromosome analysis, fragile X DNA testing, urine metabolic screen, and imaging study of the brain. In approximately one-third of children diagnosed with autism, there appears to be a history of language regression, usually at about 18 months of age. In those cases, a sleep-deprived EEG is warranted to rule out an acquired epileptiform aphasia of childhood (eg, Landau-Kleffner Syndrome).

The management of autism requires a collaborative effort. At the present time treatment consists primarily of educational and behavioral intervention. Typical recommendations for the newly diagnosed child include enrollment in a structured preschool to provide appropriate social and developmental models. The educational program needs to include speech and language therapy and occupational therapy. These services are available through Kentucky's Early Intervention System prior to age 3, and through the local public school system after age 3. Most children with autism require individualized attention with specific modifications and strategies to help achieve communication and social interaction goals. Family information and support is essential to this process. The child with autism frequently presents with significant behavior management concerns. Medication may be indicated in some children to address issues such as high activity level, inattentiveness, extreme ritualistic behavior, self-abusive or aggressive behaviors, and sleep disturbance. Successful intervention is highly dependent upon coordination of services and cooperation between professionals and family members.

An exciting new local resource in autism is the Kentucky Autism Training Center. KATC was funded by the state legislature as a result of efforts by families of individuals with autism. Its purpose is to provide school-based consultation and teacher training, family technical assistance, and training for promotion of the early identification of autism. Current and future efforts include establishing a research library and website, providing broadcasted courses and teleconferencing consultations and conducting family and school focused resources. KATC can be

contacted at 1-800/334.8635, extension 4631 or 502/852.4631. The training center provides a valuable addition to regional services in autism and complements existing services. The dissemination of the most recent information on autism should enhance interventional services and stimulate even further interest in this fascinating, complex disorder.

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ACUTE PROMYELOCYTIC LEUKEMIA

NEW METHODS IN DIAGNOSIS AND TREATMENT

Liza Varghese, MD; Anthony Janckila, PhD; Lung T. Yam, MD

Acute promyelocytic leukemia (APL) is a distinct subtype of acute myeloid leukemia characterized by hypergranular leukemic cells, bleeding diathesis and t(15; 17) translocation. The t(15; 17) translocation leads to the production of the PML-RAR α fusion protein which plays a vital role in the pathogenesis of APL by arresting normal differentiation of myeloid precursors. However, in the presence of high concentrations of all-trans-retinoic acid (ATRA), the PML-RAR α fusion protein serves to stimulate cell differentiation. The diagnosis of APL and the detection of residual disease are based on the t(15; 17) translocation. Treatment with a combination of ATRA and anthracycline-AraC chemotherapy has shown a higher rate of complete remission in APL. We report the case of a 71-year-old male with the rare microgranular variant of APL to illustrate these findings. The patient was treated with a combination of ATRA and Daunorubicin-AraC chemotherapy and achieved complete remission. He developed retinoic acid syndrome as a complication of therapy with ATRA. The methods for diagnosis, the molecular mechanisms in the oncogenesis of APL, rationale of treatment of APL with ATRA, complications of therapy and the new concepts in the treatment of ATRA-resistant APL are discussed.

Acute myeloid leukemias (AML) are a heterogeneous group of diseases with an incidence of 2.3/100,000/year. Acute promyelocytic leukemia (APL-AML-M3) is a distinct subtype comprising 10% of all cases of AML.¹ Traditionally, AML is treated with cytotoxic chemotherapy aiming to achieve total eradication of the leukemic cells. In APL, this form of treatment is frequently associated with bleeding diathesis which can be fatal.² This bleeding complication is thought to be caused by the release of procoagulant by the primitive leukemic cells from cell lysis following cytotoxic chemotherapy, and is frequently treated with heparin. With the advent of new knowledge in cell and molecular biology of leukemic cells in APL, both the method in diag-

nosis and the concept in therapy of the disease are changing. By using all-trans-retinoic acid (ATRA) to induce leukemic cell differentiation and conventional cytotoxic chemotherapy to eradicate the differentiated leukocytes, it is not only possible to avoid bleeding diatheses, but also to achieve a high rate of complete remission in APL.³

We hereby report a case of the rare microgranular variant of APL, and discuss methods for diagnosis and rationale for the new treatment for acute promyelocytic leukemia.

Case Report

The patient is a 71-year-old African American male admitted for evaluation of fever, easy fatigability, weakness and nose bleeds. Pertinent physical findings included normal vital signs, mild splenomegaly and no bleeding. Admission laboratory findings were significant for hemoglobin of 10 gm/dL, hematocrit of 29%, platelets 14,000/mm³ and leukocyte count of 22,700/mm³. The differential count was 2% neutrophils, 4% lymphocytes, 2% metamyelocytes, 5% blasts, and many abnormal monocytoid cells. PT and PTT were 16.1 seconds and 46 seconds, respectively. Fibrin split products were elevated to >40, although fibrinogen levels were normal. Bone marrow aspiration and biopsy showed the presence of many immature myeloid cells. Based on the cytologic findings of many monocytoid cells and some primitive granulocytes in both blood and marrow, a tentative diagnosis of AML-M2 or -M4 was made. This diagnosis was in question when subsequent cytochemical studies showed that the leukemic cells stained positive for myeloperoxidase, Sudan Black B, and chloroacetate esterase, but were negative for nonspecific

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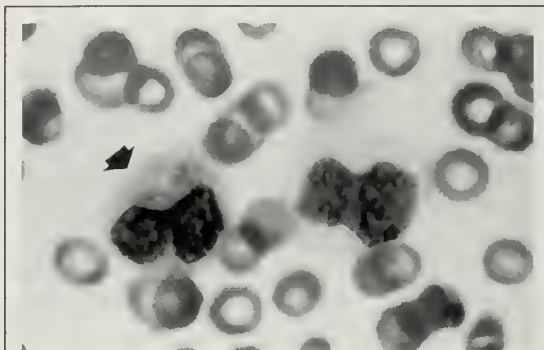


Figure 1. Leukemic promyelocytes in a peripheral blood smear of our patient. The bilobed, monocytoid nuclei and the absence of visible granules in many of the cells are characteristic features of microgranular variant of APL. A cell with granules is shown for comparison (arrow) (Wright-Giemsa stain $\times 1350$).

esterase. Further careful cytologic studies of the blood and marrow showed the presence of a few hypergranular promyelocytes and cells with typical bilobed nuclei characteristic of APL (Figure 1). The diagnosis of APL-variant was confirmed by subsequent cytogenetic studies exhibiting translocation between the long arms of chromosomes 15 and 17.

Treatment for AML-M3 was started soon after admission with Daunorubicin, Ara-C (3/7 regimen) and all *trans* retinoic acid (ATRA). Two days into the chemotherapy, the patient was neutropenic, developed respiratory distress, fever and pulmonary infiltrates which progressed to acute respiratory distress syndrome (ARDS) and acute renal insufficiency. The ATRA was discontinued. Aggressive diuresis and intravenous dexamethasone were started. Supportive treatment for infection, anemia and thrombocytopenia were given with antimicrobials, blood and platelet transfusions. G-CSF was begun 10 days after the completion of induction chemotherapy. The patient's clinical condition improved on this treatment. His hypoxia and renal insufficiency improved, returning to baseline. A second course of induction chemotherapy with Daunorubicin and Ara-C was given and ATRA was added on the 5th day of the induction therapy. The patient tolerated this well with no complications except

for extensive skin peeling, especially in the hands and soles. Bone marrow aspiration done one month later at a clinic follow-up showed moderately severe hypocellularity and no leukemic residue. The patient had been on ATRA since his discharge from the hospital. One month after his clinic follow-up he was given consolidation chemotherapy with Daunorubicin and VP-16(2/5 regime) along with ATRA, which he tolerated well.

DISCUSSION

Acute promyelocytic leukemia is a distinct subtype of AML. It is characterized by the frequent occurrence of hemorrhagic diathesis simulating disseminated intravascular coagulation. Heparin may be used to treat bleeding which occurs in APL.^{2,4} Two morphologic forms of APL are recognized: hypergranular APL and microgranular variant. The M3 variant comprises 10% of all cases of APL. In hypergranular APL, the promyelocytes are large cells with low nuclear/cytoplasmic ratio; the cytoplasm contains abundant, coarse azurophilic granules and Auer rods. The nuclear outline may be round or irregular with a folded or reniform appearance. Most patients present with leukopenia, thrombocytopenia and anemia. In the M3 variant, the promyelocytes are also large, have low nuclear/cytoplasmic ratio and an unusually lobulated or invaginated nucleus that may resemble a monocyte nucleus. However, most of the promyelocytes do not exhibit abundant coarse cytoplasmic granules. The azurophilic granules in the leukemic cells are very fine and can be visualized by electron microscopy. As with hypergranular APL, anemia and thrombocytopenia are present. In contrast to the hypergranular form though, there is usually a marked leukocytosis. Cytogenetically, the leukemic cells of both forms of APL have a balanced reciprocal translocation between chromosomes 15 and 17 resulting in the fusion of the promyelocytic leukemia gene (*PML*) on chromosome 15, to the retinoic acid receptor alpha gene (*RAR α*) on chromosome 17^{4,5} (Figure

PML and RAR α proteins are transcription factors that bind to DNA at specific promoters. Proper function of both requires dimerization; PML with PML as a homodimer and RAR α with a related RXR protein as a heterodimer. The hybrid *PML-RAR α* gene resulting from the translocation, encodes the PML-RAR α fusion protein which has a crucial role in the pathogenesis of APL by inhibiting the differentiation of myeloid precursors. The abnormal PML-RAR α hybrid in APL binds to PML and RXR, thereby preventing normal dimerization. Disruption of the function of PML in APL is believed to promote the survival and proliferation of blasts. RAR α protein has an important physiologic role in cell differentiation and growth. Interference with the formation of normal RAR α -RXR dimers blocks differentiation at the promyelocyte stage. Thus PML-RAR α fusion protein prevents the commitment and maturation of the APL precursor cells. It also promotes cell survival by inhibiting endogenous programmed cell death. The effect of prolonged cell survival combined with the differentiation block provides a cellular mechanism to account for the oncogenic potential of PML-RAR α . In the presence of high concentrations of ATRA, PML-RAR α becomes an activator of transcription rather than an inhibitor and restores RA-mediated differentiation. Thus ATRA exerts its therapeutic effect by inducing differentiation of leukemic promyelocytes into mature granulocytes; that is, by taming them rather than killing them. These differentiated leukemic cells can no longer produce leukemic clones. Cells that harbor chromosomal translocations resulting in rearrangements of the *RAR α* gene but involving chromosomes other than chromosome 15, such as t(11;17) and t(5;17), do not differentiate in the presence of ATRA.

Treatment of APL: The concept of treating APL is changing rapidly.^{6,7} Daunorubicin and Ara-C(3/7 regime) is used most often for induction chemotherapy and can achieve a high rate of complete remission (CR). Treatment failure is not normally caused by drug resistance, but by death from coagulation disorders during the

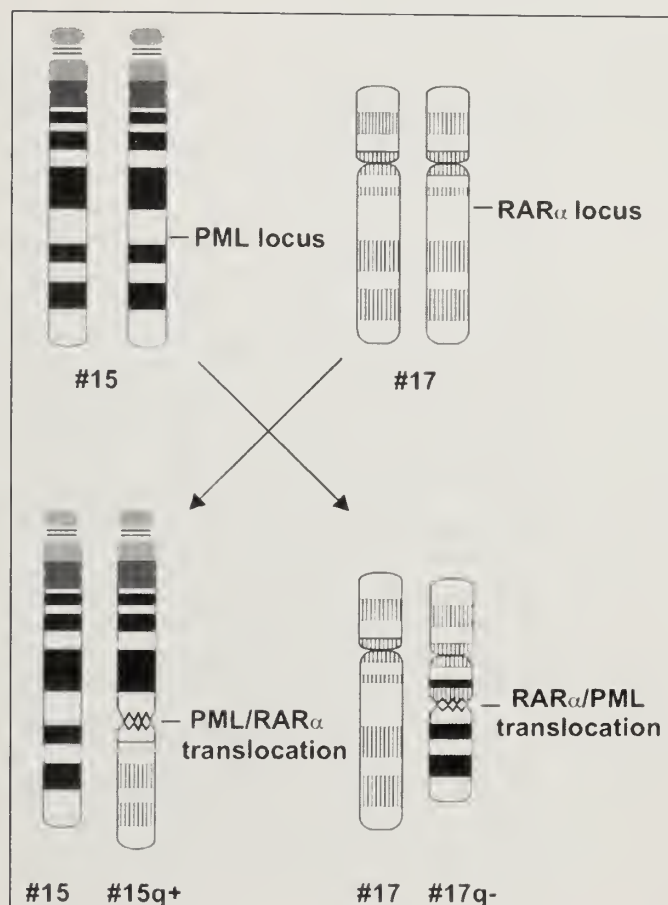


Figure 2. Schematic representation of the t(15;17) translocation of APL shows the breakpoints within the PML and *RAR α* genes. The balanced reciprocal translocation leads to fusion genes giving rise to abnormal transcription factors, PML/RAR α and RAR α /PML. These factors disrupt normal transcription through genes involved in cell growth and differentiation, including the RA responsive genes.

first days of treatment or from sepsis during post-chemotherapy aplasia. With a therapeutic strategy combining ATRA and anthracycline-AraC chemotherapy, about 70% of newly diagnosed APL cases achieve durable CR.⁶ ATRA treatment produces a high rate of CR, which is reached without a phase of bone marrow aplasia or treatment-associated coagulopathy. It is generally well tolerated. The rationale of treating APL with ATRA is derived from the effect of high concentrations of ATRA on the function of the fusion protein PML-RAR α . There is no agreement on the optimal postinduction chemotherapy. Intensive consolidation chemotherapy

seems to be useful; the value and modality of maintenance is still controversial. The results of Tallman et al⁷ suggest a benefit from continuous maintenance therapy with ATRA. Pharmacokinetic studies have shown a dramatic reduction in serum and cellular levels of all-trans retinoic acid after a few weeks of treatment, because of progressive hypercatabolism of the drug.⁶ Therefore, maintenance therapy with intermittent use of ATRA allows reversal of hypercatabolism of the drug between courses, which may give better results. The duration of complete remission after ATRA therapy varies from one month to two years. Patients relapsing after a previous treatment with ATRA are invariably resistant to further treatment with ATRA. Putative mechanisms of this acquired resistance include new mutations in nuclear retinoid receptor and induced pharmacological depression of plasma drug concentration. The exact mechanism is still unclear.

Poor prognostic factors for achieving CR in APL are: (1) age >50 yr, (2) leukocytosis at diagnosis, (3) microgranular variant, (4) fever with severe bleeding at diagnosis, and (5) thrombocytopenia. These patients have higher risk of early death. Shorter remissions are found in patients with blast count >500/mm³ in the peripheral blood, leukocytosis and M3 variant. Minimal residual disease can be evaluated by reverse-transcriptase-polymerase-chain-reaction (RT-PCR) testing for *PML-RAR α* transcript. PCR negativity should be the therapeutic goal in APL patients. A positive PCR result after consolidation chemotherapy may predict relapse.

Complications of treatment with ATRA include dry skin and mucosae and less frequently cheilosis, nasal stuffiness and itching. These side effects are short-term and easily controlled by appropriate symptomatic therapy. The specific severe side-effect of ATRA is the *Retinoic Acid Syndrome*.^{4,8,9} This occurs in about a quarter of patients, between the second day and the third week. Symptoms include fever, hypoxia, pulmonary infiltrates, weight gain secondary to fluid overload, pleural effusions, renal impairment and cardiac failure. Retinoic

acid syndrome is more frequent in APL patients like ours, who have high leukocyte counts either at presentation or during treatment. The mechanism of this syndrome is unclear, but is thought to be related to the release of cytokines from the large number of leukemic cells leading to a clinical picture quite similar to the capillary leak syndrome. This can be treated with standard chemotherapy (Daunorubicin and Ara-C) when the leukocyte count is high.⁹ High dose corticosteroids early in the course of the syndrome generally leads to prompt improvement as in our patient.

Allogeneic bone-marrow transplantation (BMT) during first complete remission has been used in APL. Results from large retrospective studies show a disease-free survival of between 40-60% which is inferior to that currently available with ATRA and chemotherapy combination.¹⁰ Thus, BMT does not appear to be the treatment of choice in first complete remission APL patients. Arsenic trioxide induces apoptosis of leukemic blasts, providing another way of eliminating blasts in APL. In patients who become resistant to both ATRA and anthracycline-cytarabine, effective chemotherapy can be obtained with Arsenic trioxide.¹¹

Except for a few diseases, the general approach to treatment of neoplasia by killing agents has limited success and always harmful side effects. This is because such methods are generally nonspecific. Treatment by recoupling proliferation and differentiation, thereby "taming" the disease, is much more attractive to physician and patients, and could be a much more effective disease control or cure. This requires knowledge of the specific molecular lesions responsible for the oncogenic event and the consequences of such lesions have on cell biology. APL is one of a few model diseases which illustrates how research into the molecular biology of neoplasia can lead to new and effective treatments based on these discoveries.

ACKNOWLEDGMENTS: The authors thank Ms Deena Davis and Ms Luann Jagers for their expert technical assistance. This work was supported in part by the Research Service of the Department of Veterans Affairs, The University of Louisville Hospital, and the Jewish Hospital Foundation, Louisville, KY.

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THE HISTORY OF OPERATIVE GYNECOLOGIC LAPAROSCOPY IN KENTUCKY

Ronald L. Levine, MD; Marvin A. Yussman, MD

Frequently we tend to think of ourselves as middle Americans who only follow the developments on the east and west coasts and in the prestigious academic centers of our country. However, we, as Kentuckians, can take a great pride in the leadership in medicine that has been spawned in our state. Our heritage reaches from the 19th century work of Ephraim McDowell, who, in 1809, performed the world's first ovariectomy, to the marvelous advances in hand surgery by Drs Kleinert and Kutz and the impressive strides in cardiovascular surgery by Drs Lansing, DeVries and Gray of recent decades.

We believe the efforts of the faculty of the University of Louisville School of Medicine, Department of Obstetrics and Gynecology, have had equal, if not as noted, impact on the development of laparoscopy, not only in the state of Kentucky, but also on a national scale. The story of these contributions may be of some interest to the general medical community.

The history of endoscopy is long, intriguing, and certainly beyond the scope of this paper. Although operative laparoscopy was performed as early as 1947 by Palmer in France, the American experience with gynecologic laparoscopy probably began when Cohen and Fear from

Chicago wrote the first American publications on gynecologic laparoscopy in almost 30 years in 1968,^{1,2} and in 1970 Clifford Wheelless reported on outpatient laparoscopic tubal sterilization from The Johns Hopkins University.³ The early 1970s witnessed the spread of laparoscopy to Kentucky when Dr Marvin Yussman, currently Professor of Obstetrics and Gynecology at the University of Louisville, returned to Louisville from his fellowship in Reproductive Endocrinology at Harvard University and performed the first laparoscopy in the state in September 1970 at Jewish Hospital in Louisville. Shortly thereafter, he trained Dr Levine who began laparoscopic tubal sterilizations at the same hospital in November 1970. Although gynecologic laparoscopy as it is known today was introduced by Dr Yussman to Kentucky, "Peritoneoscopy" had been used experimentally by Dr Joseph E. Hamilton, the Chief of Surgery at the V.A. Hospital in Louisville from 1951 to 1953. He used a rigid cystoscope without insufflation to look for tumors of the liver.⁴ He made a small incision in the right upper quadrant and passed the scope directly into the abdomen. Visibility was so limited that he soon abandoned this approach. The original insufflators used by Yussman and Levine were "home made" from

an old anesthesia apparatus with the pressure controlled by passing the carbon dioxide gas through a cylinder of water. A special needle used for insufflation had been invented much earlier in 1938 by Dr Janos Verres, a Hungarian pulmonologist. He used this needle to induce a pneumothorax to treat pulmonary tuberculosis.

In the early days, there was a great trepidation on the initial insufflation. As a guide line, the risk was reduced by limiting the procedure to non-obese patients. Women who weighed more than 150 pounds were considered poor candidates for laparoscopic surgery. As skills improved, the allowed weight was elevated, first to 175 pounds, then 200 pounds, until finally some years later there was no cut off. Indeed, Dr Walter Wolfe, presently an Associate Professor in the Ob-Gyn Department, began research, that was carried on by Dr Resad Pasic, into laparoscopy on morbidly obese patients. They collected outcome data on more than 130 patients who had a body mass index of more than 36. The heaviest patient in their series weighed 400 pounds! Dr Wolfe developed alternate insufflation techniques and published a paper with Dr Pasic in 1990 describing the transuterine insertion of the Veress needle in obese patients.⁵ In the early 1970s, Dr Wolfe

obtained some laparoscopic equipment with Title X funds to be used at Louisville General Hospital for diagnostic laparoscopy. This equipment was also used by Dr Yussman at Jewish Hospital.

In 1980, Dr. Levine presented a paper in Acapulco, Mexico, on 10 years of experience with laparoscopic sterilization. At this time he met Dr Kurt Semm from Kiel, Germany. Dr Semm was performing many types of gynecologic surgery by laparoscopy including oophorectomy, myomectomy, and lysis of severe adhesions; he was the first to describe a laparoscopic appendectomy in 1980. Although there were many who did not believe the reports from Kiel or who called the operations "gimmick" surgery, Levine decided to find out personally. In September 1983, Dr Levine spent 10 days in Kiel and came to believe that this surgery was the wave of the future.

Upon returning to Louisville and with support from Jewish Hospital, laparoscopic surgical supplies were purchased directly from Germany, as there were no such types of equipment available in this country. Materials such as a high flow carbon dioxide insufflator, a variety of laparoscopic graspers, scissors, morcellators and other necessary items needed to perform this type of surgery were all obtained at that time. All the equipment was labeled in German and all fittings for gas supplies had to be changed

from European to American. The assembly of the supplies was a formidable one as neither Levine nor the nursing personnel read scientific German well enough to follow the directions. Luckily, an obstetric nurse, Helga Rosenbluh at St. Anthony hospital, who was from Germany, assisted in the translation sufficiently to allow the completion of the task.

The first recorded operative laparoscopy in the state was performed in December 1983. In 1985, Levine published the first case of bilateral laparoscopic oophorectomy reported in this country in a paper entitled, "Economic Impact of Pelviscopic Surgery."⁶

Dr Wolfe and Dr Yussman began training residents in this technique and in 1986, with encouragement from Dr Byron Masterson, then Chair of the Department of Ob-Gyn at the University of Louisville, hosted the first University-sponsored course in operative laparoscopy held in the United States. The faculty, other than Dr Semm, were all Americans who were pioneers in endoscopy and whose names read like a who's who in endoscopic surgery. Dr Jaroslav Hulka, Dr Harrieth Hasson, Dr Harry Reich, and Dr John Leventhal complemented the local faculty. The University of Louisville continued to hold an annual course for endoscopic surgery for the next 5 years. The Ob-Gyn Department was responsible for the initial training of many laparoscopic surgeons from

all parts of the United States and provided the training ground for several who went on to become the luminaries in the field.

In 1989, Dr Joseph Sanfilippo, presently the Professor and Chair of the Department of Obstetrics and Gynecology at the Allegheny University of Health Sciences in Pittsburgh, Pennsylvania, and Levine co-authored one of the first American textbooks in operative gynecologic endoscopy, a book that progressed to the publication of a second edition in 1996.⁷

Kentucky has been the site for the beginning of many medical advances, and laparoscopy has certainly been among the highlights of pioneering in medicine in our state.

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"GAG CLAUSES" ARE STILL A DANGER TO PHYSICIANS

Patrick T. Padgett, Esq

The Kentucky Medical Association sponsored and passed legislation during the 1998 General Assembly outlawing so called "gag clauses" between health plans and physicians. Despite this legislation, some health plans may still put gag clauses in their contracts and some physicians may not even know if such a clause is in their contracts. This article, therefore, is designed to educate physicians on gag clauses and provide examples of the type of wording such a provision might contain.

WHAT IS A GAG CLAUSE?

Gag clauses are provisions in a contract between a health plan and a physician that limit what a physician might be able to tell a patient. Health plans argue that such provisions are used, not to limit discussion about medical treatment between physicians and patients, but to protect proprietary information and prevent physicians from airing frustrations about the changing health care market with their patients.¹ In essence, however, these provisions are anticompetitive, interfere with the confidential physician-patient relationship, and may obstruct a physician from fully discussing all treatment options with the patient. These clauses can be so damaging to the physician-patient relationship, the American Medical Association began a campaign nearly two

years ago to fight the use of gag clauses and successfully obtained the removal of such provisions from some health plan contracts, most notably Aetna.

Many times gag clauses are inserted into a contract, but physicians would not know it if they saw it. Below are some examples of gag clauses, which come from actual contract language in health plan contracts with physicians:²

- *This contract may be immediately terminated for provider's direct contact of plan members in regards to matters pertaining to the plan without plan's prior written approval or provider's making any repeated disparaging remarks at plan or expressing opinions regarding the plan or any of its affiliates that are negative in nature.*
This provision says a physician can have no "direct contact" with a patient "in regards to matters pertaining to the plan." This statement is very broad. It prevents a physician from discussing treatment options the plan might offer, as well as other aspects of the plan. The clause also prohibits physicians from "making any repeated disparaging remarks." If the physician tells a patient that the plan is "slow" in approving certain treatments, is that a "disparaging" statement?
- *Any dissatisfaction with the Specialist program should be communicated directly to the Plan*

rather than to patients or other physicians. A Specialist Physician who engages in a pattern of derogatory remarks to patients or otherwise damages Plan's business reputation may be suspended or terminated from participation in the Specialist program.

This statement says that the physician must communicate with the plan if there are any problems the physician might have with the plan. If the physician believes that a service should have been approved by the plan when it was not, the physician, according to this provision, can only communicate such disagreement with the plan — not the patient.

- *Physician shall keep the proprietary information (payment rates, utilization review procedures, etc) and this agreement strictly confidential.*
Such a provision could be taken to mean that physicians may not discuss with patients costly procedures or how decisions regarding medical necessity are made by the plan. Of course, this provision also contains the broad term "etc" when describing what is not allowed to be discussed with the patient. This could mean just about anything.
- *Physicians shall take no action nor make any communication which undermines or could undermine the confidence of Enrollees, potential Enrollees, their employers, Plan Sponsors, or the public in*

"GAG CLAUSES" ARE STILL A DANGER TO PHYSICIANS

[Plan] or in the quality of care which [Plan] Enrollees receive.

Physicians shall make all endeavors to make positive communication about the plan and will refrain from making any disparaging comments about the plan, or may comment that would tend to undermine the confidence of patients in the plan.

Each physician must be supportive of the philosophy and concept of the plan.

These provisions could mean that the physician cannot discuss anything with the patient that might make the patient think the plan is inadequate to meet his needs. Thus, a physician could not discuss the non-availability of sufficient numbers of specialists in a plan panel. Or, for patients with severe problems, alternative treatments could not be discussed because a plan may not cover them.

- *Provider shall use its best efforts to ensure that no employee of the PROVIDER or subcontractor of the PROVIDER makes any derogatory remarks regarding [Plan] to any member.*

This provision ensures that the "gag" applies, not only to the physician, but also to the physician's employees "or subcontractor" (cleaning crew?).

NEW LEGISLATION

In response to the use of such clauses, as well as the favorable political climate created by managed care's poor reputation, the KMA passed legislation in 1998 banning gag clauses from health plan contracts. The new law states:

- (1) A managed care plan may not contract with a health care provider to limit the provider's disclosure to an enrollee, or to another person on behalf of an enrollee, of any information relating to the enrollee's medical condition or treatment options.
- (2) A health care provider shall not be penalized, or health care provider's contract with a managed care plan terminated, because the provider discusses medically necessary or appropriate care with an enrollee or another person on behalf of an enrollee.
 - (a) The health care provider may not be prohibited by the plan from discussing all treatment options with the enrollee.
 - (b) Other information determined by the health care provider to be in the best interests of the enrollee may be disclosed by the provider to the enrollee, or to another person on behalf of the enrollee.
- (3) (a) A health care provider shall not be penalized for discussing financial incentives and financial arrangements between the provider and the insurer with an enrollee.
 - (b) Upon request, a managed care plan shall inform its enrollees in writing of the type of financial arrangements between the plan and participating providers if those arrangements include an incentive or bonus.³

USE OF GAG CLAUSES

Since Kentucky has now passed a law prohibiting gag clauses, health plans will not place them in contracts with physicians . . . right? Not necessarily. During the AMA campaign to ban gag clauses, Congress conducted hearings regarding the use of such clauses in health plan contracts. Prior to the hearings, congressional staffers were unable to find any health plan contracts that contained gag clauses. In fact, health plan leaders argued that none of their contracts contained such clauses.

Just before the start of the Congressional testimony, however, the AMA obtained a bulletin sent out by Humana which was meant to set new guidelines for preadmission review. The bulletin stated, in part, "Effective immediately, all Humana participating providers must telephone the preadmission review department . . . before an admission occurs and *before conveying the possibility of admission to the plan member.* Many group contracts specify a 50% penalty for not getting pre-admission review authorization before the patient is sent to the hospital."⁴ This bulletin was presented to Congress to show that health plans still placed gag clauses in their contracts.

Some health plans, most notably "self insured" plans, might place a gag clause in their contracts because, they argue, the federal ERISA law preempts Kentucky state law. The United States Supreme Court, however, has held that ERISA does not

preempt state laws that can be characterized as an exercise of the power of "general health care regulation," including "quality standards."⁵ A prohibition on gag clauses is certainly designed for the regulation of general health care in the state, which has nothing to do with mandated benefits of a plan.

Some health plans might also argue that, while their contracts do contain gag clauses, the gag clauses are simply unenforceable, so there is no need to take them out. This argument, however, has no merit. Kentucky law is quite clear that contracts may not contain gag clause language that would attempt to bind a physician.⁶ There is also another Kentucky law which says that no one may "knowingly and willfully transact any [insurance] contract, agreement, or investment which violates [the law]."⁷

Not only are gag clauses detrimental to the physician-patient relationship, they might also create additional liability for a physician. Kentucky law makes it clear that patients must give "informed consent" to a physician for any type of service or treatment.⁸ By failing to discuss all available treatment options, a

physician might not give enough information for the patient to provide informed consent. This might create liability for the physician. Also, if a gag clause is contained in a contract, the patient might have an argument that the physician was legally bound not to give information necessary for informed consent.

CONCLUSION

Physicians should review their contracts to determine if they contain gag clauses. If a contract does contain such a clause, the AMA suggests that the physician not just "X" out the language and send it back to the health plan. This may not be binding on the plan.⁹ Physicians should negotiate to have the language removed and Kentucky's law banning such clauses is very good leverage for a physician to use during such negotiations. Physicians should also seek to have language put in their contracts that protects them from liability. Such language might say, "Nothing in this contract shall be construed to impede the physician's ethical and legal duty to provide full informed consent in medical counsel to patients."¹⁰

While health plans might argue that gag clauses are meant to protect their business interests, a physician should be able to discuss all treatment options with a patient. The health of the patient should always come before the bottom-line of a managed care company.

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Mr Padgett is Director, Socio-economic Affairs/Staff Counsel for the Kentucky Medical Association.

THE KMA WANTS TO KNOW

The KMA would like to know if gag clause language is being used in health plan contracts. If you think you have a contract that contains such language, please send the contract to the KMA or contact the KMA legal department.

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Kimberly A. Alumbaugh, MD

A ZEAL TO HELP

He called back within minutes of her plaintiff call.

I know this is unusual, she said, but an old friend from high school has an 8 year old who has suffered a series of strokes. The physicians with whom they are working have become resigned to a particular nonspecific diagnosis, and the family's access to specialists is being somewhat limited by their health plan structure. I need to know who to tell them to seek out. I need to offer them any help that is available. I know this is an imposition on your time from a distant patient you have never seen, from a colleague you have never met, but if you have a moment . . .

He called her back within minutes with a level of care and compassion, interest and zeal that she had not seen in a very long time (at least not from someone for whom there was so very little secondary gain).

After two or three intermediary calls, he frankly asked her if the family would object to him calling directly, this evening, after he finished rounds. Sorry, he said, but it will be after nine. I hope they won't mind. At this point, I assured him, a glimmer of interest from a physician of his

stature would be welcome well into the wee hours of the morning.

He softly said, "It is so tragic when this happens to a family. There must be a better answer, there must be more that can be done." He was so refreshingly concerned about the child, so blithely unconcerned about the addition to his already heavy load and the inconvenience of dealing with a lay person over the phone with no objective data before him.

Andrew is a doctor, and for it we are all made better. He has remembered the oath and he refuses to let the pressures of the day sway him from what is the right, not utile, thing to do.

The next day amidst multiple time conflicts, patient encounters, insurance precertifications, and imagined emergencies, I promised to remember Dr Reisner as I picked up the phone to attack the burgeoning berm of calls before me. I will try to remember him daily — his commitment, his example, his zeal to help.

Within minutes I returned a call.

Kimberly A. Alumbaugh, MD

*Andrew is a doctor,
and for it we are all made
better. He has remembered
the oath and he refuses to
let the pressures of the day
sway him from what is
the right, not utile,
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Jan Crase

AFFAIRS (OF THE HEART)

The KMAA came into existence because of you physicians and your profession, at your request, and is still working closely with the KMA to promote quality health care and sound health legislation.

The Affairs of which I speak have nothing to do with Bill Clinton nor the affairs of any other politician in Washington, or elsewhere for that matter. Sorry to disappoint you, but the affairs of which I speak aren't even sexual. (But then, I guess that depends upon your definition of sex.) I speak of Affairs of the heart as being those ideas and accomplishments our two organizations share that are dear to our hearts and truly meaningful for extended periods of time.

The KMA and the KMAA have shared many "Affairs of the heart" over the past 75 years. The KMAA came into existence because of you physicians and your profession, at your request, and is still working closely with the KMA to promote quality health care and sound health legislation. The Alliance also reaches out and works with other organizations with similar goals to accomplish what we could not do alone. These outreach efforts have the blessing of the KMA. As a state organization, the KMAA serves as the link between County Alliances and the National Alliance to provide leadership training, resource materials, and support to physician families. Addressing public health issues is also at the heart of the Alliance activity.

Following is an update of some recent and upcoming KMAA activities:

Teacher's Breast Cancer Awareness project statistics:

In the September '98 KMA Journal article, *The Loaves and the Fish*, I reported that the KMAA, after learning teachers have a 60% higher mortality rate of breast cancer, joined forces and worked with several other organizations to reach, as it turned out, about 88,000 teachers and staff in Kentucky, in May '98, with a flyer which stressed the importance of mammograms and early diagnosis of breast cancer.

A survey to get some evaluation of this effort was developed by Gloria Sams with the Kentucky Cancer Program, and KMAA member Victoria Moore, (PhD in Measurement Statistics), with the help of representatives from both the Department for Public Health and the KMAA. The surveys were distributed by the Kentucky Cancer Program to select schools in Eastern, Western, Central, and Northern Kentucky. The school district superintendents readily agreed to distribute the surveys to their teachers and staff and even assisted in getting responses. In addition to geographic diversity, the survey included other variables such as county /

independent, large/medium/small, and urban/rural. Not being a statistician, my inclination was to survey everyone; however, I learned research has shown that after a certain number, one does not get any *new* information, just *more* of it. We got replies from almost 2½ times the recommended minimum number. The distribution was designed for an October response, and Somerset Community College faculty Roger Angeveine and Jonnie Blair volunteered their evaluation expertise using a new computer program that had recently been purchased for the college. In an effort to get a higher percentage of response to the survey, incentives were provided by having a drawing of the respondents' names for four different prizes. There was a 23.5% response! The survey results indicated 35% of the **total** respondents had a mammogram.

Forty-nine percent of those females over age 40 had mammo-grams as compared to only 33% of the general population. When one considers that teachers must have a lower mammography screening rate than the general population (hence their higher mortality rate) the compliance rate of those in our sample is pretty phenomenal. Also, 8% of the respondents had an abnormal mammogram and in .006% cancer was diagnosed. There is no way to know if the numbers in our relatively informal survey reflect the statewide population of Kentucky Department of Education Employees; however, if it does, the numbers are far greater than one might anticipate. If statewide numbers were similar to those of the survey population, that would mean —

Of 88,421 employees, if 35% got mammograms, that total would be: 30,947

If .006 of those who got a mammogram received a diagnosis of cancer: 185

If .08 of those who got a mammogram received abnormal mammogram: 2,475

The statistics of this study indicate this "Affair of the heart" was a worthwhile project. Copies of the complete survey results will be available upon request.

Southern Medical Association Alliance Awards: SMAA each year presents awards to states and counties in three different areas of activities — Medical Heritage, Health Education, and Doctor's Day Celebrations. At the

SMAA Convention in New Orleans, **Kentucky** was awarded **first place** with its Medical Heritage project (documentary video of Dr Louise Hutchins), **second place** with its Breast Cancer Awareness project (Gwyn Parson, KY SMAA Councilor) and **third place** with its Doctor's Day Celebration (Marla Vieillard, KY SMAA Councilor). Also, **Pulaski County** was awarded **second place** with its Health Education project. These awards represent much work on the part of many people. Congratulations to each person involved!

Membership and Convention:

The Alliance membership drive is still on, so if your spouse is not a member, please remind him or her to join. Also, the KMAA Annual Meeting is planned for April 19, 20, 21 in Somerset. Some fun things are being planned including a casual outing and you are invited to accompany your spouse to the meeting, to just relax and make it a family affair or perhaps enjoy your own affair of the heart.

The KMAA is trying to help improve the image of medicine and trying to improve the quality of life for the medical family. As the KMA and the KMAA grow older together, may we also grow in our commitment to choices for both patients and physicians, our commitment to quality care, and may we continue to share "Affairs of the Heart."

Happy Valentine's Day!

Jan Crase
KMAA President

KMA 1999 Practice Management Series

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Stark Law, 6:00 pm – 8:00 pm

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Learn how to **Avoid** an **Audit** by identifying the red flags your office may wave every time claims are submitted to a carrier. KMIC provides **Risk Management** strategies for effectively working with patients if a mistake is made.

When and Where:

April 20, Louisville
April 21, Covington
April 22, Lexington

Audit-proof, 8:30 am – 3:30 pm
Risk Mgmt., 4:00 pm – 6:00 pm

Advanced Coding and Corporate Compliance

The sequel to the Coding Basics course in February - attend and learn proven **Advanced Coding** techniques. **Corporate Compliance** courses are repeats of the courses KMA provided in February.

When and Where:

May 11, Louisville
May 12, Lexington
May 13, Covington

Advanced, 9:30 am – 4:30 pm
Compliance, 6:00 pm – 9:00 pm

Managed Care and Corporate Compliance

Learn the basics of the key issues surrounding **Managed Care** from the physicians' viewpoint and how to reorganize your practice. **Corporate Compliance** is a repeat of the courses provided in February and May.

When and Where:

June 1, Somerset
June 2, Owensboro
June 3, Hopkinsville

Managed Care, 9:30 am – 4:30 pm
Compliance, 6:00 pm – 9:00 pm

Workshop Pricing

	<u>Member</u>	<u>Non-member</u>
Coding, Audit-proof and Managed Care	\$195	\$215
Compliance and Stark Law	\$79	\$99
Both for Discount Fee	\$245	\$300
KMIC Risk Mgmt.	<u>Physicians</u> \$50	

Registration Information

To register, please contact Marty White by phone at (502) 426-6200, by fax at (502) 426-6877 or by e-mail at white@kyma.org. Please include the following information with your fax or e-mail: Name, Practice, Address, City, State, Zip, Phone, Fax, E-mail (if applicable) and which seminar(s) and location(s) you want to attend. You will receive confirmation of your registration with an invoice for the amount of the seminar fees.

1998-99 NEW OFFICERS' PROFILES

During the 1998 KMA Annual House of Delegates meeting held in Louisville, three new officers were elected to serve on the Board of Trustees. KMA congratulates these members on their election and thanks them for their valuable leadership.



BARETTA R. CASEY, MD
Fourteenth District Trustee

A board certified family physician practicing in Pikeville, Dr Casey was elected to serve a 3-year term as Fourteenth District Trustee. This follows her service as Alternate Trustee in 1995-1998.

Dr Casey began active involvement with KMA in 1986 in the Medical Student Section and was elected KMA-MSS Governing Council President in 1990. She currently serves as an Alternate Delegate to the AMA, is a member of the KMA Physician Workforce Committee, chairs the KMA Committee on Community and Rural Health, is President of the Pike County Medical Society, and is Assistant Treasurer of KEMPAC. A member of the AMA National Coalition of Physicians Against Family Violence, Dr Casey chairs the KMA Subcommittee on Domestic Violence and the Pike County Domestic Violence Board, Inc. She served as a member of the Commonwealth of Kentucky — Governor's Task Force on Domestic Violence Crime in 1995 and was honored with the 1995 AMA-YPS Community Service Award for her work in domestic violence.

A native of Kentucky, Dr Casey, 45, graduated cum laude from Pikeville College in 1984, and in 1991 earned her MD from the University of Kentucky College of Medicine, where she currently serves as a volunteer assistant professor. She also is Adjunct Clinical Professor of Family Practice at Pikeville College School of Osteopathic Medicine.

Dr Casey and her husband, Mike, reside in Pikeville, where she is in a solo practice with privileges at Pikeville Methodist Hospital.



UDAY V. DAVE, MD
Third District Trustee

A board certified otolaryngologist practicing in Madisonville, Dr Dave was elected to serve a 3-year term as Third District Trustee.

An active member of KMA since 1979, he has served continuously as a KMA Delegate from Hopkins County since 1992. Dr Dave currently serves as a representative to the AMA Organized Medical Staff Section and as Associate Councilor (Kentucky) for the Southern Medical Association. Other professional memberships include the World Medical Association, the American Academy of Otolaryngology and Head and Neck Surgery, and the Kentucky Society of Otolaryngology and Head and Neck Surgery (a group he has served as President). He also finds time to be involved in several community and civic organizations.

Dr Dave, 61, earned an undergraduate degree in 1959 from the University of Bombay, Bombay, India. He achieved his medical education at the All India Institute of Medical Science, New Delhi, India, receiving a Medical Degree in 1962 and a Master of Surgery (Otolaryngology) in 1965. He completed residencies in otolaryngology at Joyce Green Hospital in Kent, England, in 1969, and the Long Island Jewish/Queens Hospital Center, Jamaica, NY, in 1973. This was followed by the 1978 completion of a fellowship in otolaryngology, head, neck and facial plastic surgery at the Medical College of Pennsylvania, Philadelphia.

Dr Dave and his wife, Aroona, immediate past KMAA President, reside in Madisonville, where he is affiliated with the Trover Clinic. He has privileges at the Regional Medical Center.



DAVID A. WATKINS, MD
Second District Trustee

A board-certified family physician practicing in Henderson, Dr Watkins was elected to complete the 3-year term of Trustee Donald R. Neel, MD, upon Dr Neel's election as KMA Vice President. Dr Watkins had been serving the Second District as Alternate Trustee.

An involved member of KMA since 1975, Dr Watkins will continue his service on the Committee on Care for the Elderly in addition to his duties as Trustee. He served as a Henderson County Delegate to the KMA in 1998.

In addition to membership in the Henderson County Medical Society and the Kentucky Medical Association, Dr Watkins is a member of the AMA and the American Academy of Family Practice. He also participates in several community and civic organizations.

A native of Henderson, Dr Watkins, 55, earned his undergraduate degree at Western Kentucky University, Bowling Green, in 1966, and Medical Degree from the University of Louisville School of Medicine in 1973. He completed an internship at St. Mary's Hospital, Evansville, Indiana, in 1974.

Dr Watkins shares a practice in Henderson with his son, Scott A. Watkins, MD. He has privileges at Methodist Hospital in Henderson and St. Mary's Hospital in Evansville, Indiana.

Dr Watkins and his wife, Peggy, reside in Henderson.

NEWSMAKERS

Dennis B. Kelly, MD, Lexington, has received the Fayette County Medical Society's top award for community service. A specialist in cardiovascular diseases, Dr Kelly was named recipient of the 1998 Jack Trevey Community Service Award. Presented annually, the Trevey Award is given to a Fayette County physician, "who has gone beyond the role of a practicing physician in the performance of outstanding service to the community."

The American Cancer Society (ACS) has presented its prestigious Humanitarian Award to **Gilbert H. Friedell, MD**, of Lexington. The ACS presents this award for dedication to the improvement of cancer control and for genuine accomplishment in human welfare. Dr Friedell's initiatives on behalf of the poor and under served exemplify both.

The Award was presented by the American Cancer Society Chairman and reads: "For his vision in recognizing the changing nature of human and financial resources available to help the poor with cancer problems and for recognizing the potential in community collaboration; for his leadership and insight that have enabled almost 1,000 health and cancer outreach workers from competing agencies to work together to control cancer in under served populations; and for his initiatives on behalf of the

poor and under served that have saved countless numbers of people with cancer in Appalachia and the rural South."

Dr Friedell is Director Emeritus of the University of Kentucky Markey Cancer Center and the head of the Kentucky Cancer Registry and the National Cancer Institute's Region 9 Cancer Information Service, which serves Kentucky, Arkansas, and Tennessee. Until his retirement in July, Dr Friedell served as Director for Cancer Control at the Markey Center and Co-Director of the Kentucky Cancer Program.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

BOYD

Arnold N Brownstein MD OPH
2430 Winchester Ave Ste B
Ashland 41101

1975, Chicago Med School
Carter H Gussler MD OPH
2301 Lexington Ave Ste 105A
Ashland 41101

1994, U of Kentucky
Lenoard Lapkin MD TS
2301 Lexington Ave Ste 125
Ashland 41101

1985, U of Illinois, Chicago
Rahul D Patil MD IM
4736 Southern Hills Dr
Ashland 41101-9203

1988, U of Bombay, India
Traci A Sanchez MD PUD
PO Box 1380

Ashland 41105
1992, U of New Mexico
Galen A Weiss MD ORS
1180 Saint Christopher Dr, Ste 202
Ashland 41101
1991, U of Louisville

BOYLE

Jill S Ransdell MD PTH
580 Beaumont Ave
Harrodsburg 40330
1990, U of Kentucky

CLARK

Terry L Troutt MD PMR
136 Professional Ave Ste 8
Winchester 40391
1994, U of Kentucky

DAVIESS

Geraldo Bandel MD
815 E Parrish Ave Ste 410
Owensboro 42303
1984, U of Guayaquil, Ecuador
Lee S Clore MD FP

1020 Hathaway St
Owensboro 42303
1993, U of Kentucky

Thomas G Furgason IV MD OPH
1411 Woodbridge Tr
Owensboro 42303
1994, U of Kentucky

Yogesh K Gandhi MD ONC
815 E Parrish Ave Apt 170
Owensboro 42302

1989, U of Baroda, India
Geoffrey L Hulse MD ORS
2211 Mayfair Dr Ste 306
Owensboro 42301

1993, U of Louisville
William R Martin MD ORS
2816 Veach Rd
Owensboro 42303

1989, Northwestern U Womens,
Illinois
Ruth M Wieland MD IM
815 E Parrish Ave Ste 104
Owensboro 42303

1995, American U of the
Caribbean

FAYETTE

Larry S Butler MD OBG
Dept of OBGYN
University of Kentucky
Lexington 40536
1979, U of Kentucky

FRANKLIN

Sarah A Cawthorn MD OBG
101 Medical Heights Dr Ste D
Frankfort 40601
1994, U of Louisville
Wesley B Roney MD R
299 Kings Daughter Dr
Frankfort 40601
1993, U of Louisville

HARDIN

Linnea L Smith MD PD
531 Sunningdale Way
Elizabethtown 42701-8667
1995, U of Louisville
Joan Christine Temmerman MD FP
1239 Woodland Dr
Elizabethtown 42701
1994, Rush Med School, Illinois
Robert D Toon MD ORS
1412 4th Ave
Ft Knox 40121
1973, U of Chicago

JEFFERSON

Jaime M Guerrero MD AN
302 Stag Cir
Sellersburg 47172-9774
1993, U of Louisville
William R Hoffman MD FP
1601 Chukkar Cove Ct
Louisville 40245
1992, U of Louisville

KENTON

Paul A Jacobs MD OBG
3085 Sentry Dr
Covington 41017-8141
1993, U of Kentucky
John Joseph Ward MD GE
196 Barnwood Dr
Edgewood 41017-2573
1992, Ohio State

MASON

Jayantilal Ramdas Patel MD P
611 Forest Ave
Maysville 41056
1975, U of Baroda, India

PIKE

Katrina B Briggs MD AN
97 Cedar Creek Rd
Pikeville 41501-1456
1992, Marshall U, W Virginia
Lorenzo D Nichols III MD ORS
411 Auxier Ave
Pikeville 41501-1201
1992, U of Tennessee
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104 Poplar St Apt 206
Pikeville 41501
1991, U of New England, Maine

ROCKCASTLE

Jon Anthony Arvin MD FP
185 Newcomb Ave
Mt Vernon 40456
1985, U of Kentucky

SCOTT

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1162 Lexington Rd Ste A
Georgetown 40324
1992, U of Louisville

WHITLEY

Deb K Banerjee MD IM
1040 18th St
Corbin 40701
1985, LTMM Col, India

IN-TRAINING

JEFFERSON

Robert K Atteberry MD PD
James H Blackburn II MD PS
Christina L Butler MD P
Michael J Dacey MD D
James M Frazier MD PD
Pushpalatha Gogineni MD IM
John W Gouldman MD TS
Susan M Haffner MD PD
Nadeem E Haq MD OPH
Stephen J Houghland MD IM
Ayub Hussain MD GE
Veronica A Kavorkian MD FP
Meredith L Kehrner MD FP
Craig J Kozler MD S
Karen J Langness MD FP
Charles L Levy MD NS
D Matt McDanald MD OBG
Scott C Miller MD S
Kelli J Mudd MD OBG
Raul Nakamatsu MD IM
Phyllis A Neef MD PUD
Robert I Oliver Jr MD S
Lakshmana K Pendyala MD IM
Noel L Phipps MD IM
Michele G Phipps MD EM
Michelle D Pisa MD IM
Nithin C Reddy MD S
Heather R Resse MD OBG
Bret A Riegel MD EM
Eric P Sabonghy MD S
Ronald A Schrodtt MD IM
Darshana J Sheth MD FP
Jean A Smith MD P
Sarah E Snell MD S
Shilpa H Thakkar MD AN
Sarah A Tieman MD PD
Radhika Veeramachaneni MD IM
Monica A White MD OBG
William R Wrightson MD S

OBITUARIES

Marion G. Brown, MD
Lexington
1913-1998

Marion George Brown, MD, a retired orthopedic surgeon, died December 6, 1998. Dr Brown was a founding member of the Kentucky Surgical Society and past president and founding member of the Kentucky Orthopedic Society. He graduated from Vanderbilt University School of Medicine in 1939 and was a life member of KMA.

Kurt Ackermann, MD
Louisville
1910-1998

Kurt Ackermann, MD, a retired ophthalmologist, died December 13, 1998. A 1935 graduate of the University of Vienna, Dr Ackermann was a life member of KMA.

Rural Kentucky Medical Scholarship Fund, Inc

The Rural Kentucky Medical Scholarship Fund is accepting applications from residents of Kentucky, who have been accepted to one of the state's accredited medical schools. The Fund offers a \$12,000 loan for each year of medical school to a qualified recipient who is willing to practice and reside in a rural county in Kentucky for one year for each loan received. Repayment options include low interest rates for recipients practicing in rural areas and loan forgiveness for those practicing in areas of the state with critical needs. Counties considered to be rural and critical are determined by the RKMSF annually. The Fund is the oldest and most successful of its kind in the nation. The Rural Kentucky Medical Scholarship Fund has loaned approximately \$4 million to over 600 medical students. The deadline date for filing an application is *April 1, 1999*. Those interested in applying for a scholarship loan should contact the RKMSF Office at the Kentucky Medical Association Headquarters, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222, or call 502-426-6200.

KMA Board Appoints Two New Committees

- Ad Hoc Committee on Cardiovascular Services, Robert Goodin, MD, Louisville, Chair. The Committee will accumulate and evaluate data relating to cardiovascular services and consider the propriety of quality assurance criteria to assure equitable standards for physician participation in service networks.
- Committee on Managed Care, William Monnig, MD, Edgewood, Chair. The Committee will discuss Kentucky payer policies and contracts, meet with representatives of payers, discuss training needs for physicians on business issues, and serve as a forum for IPAs to discuss issues of common interest.

AMA Acts to Stop Violence Against Physicians

The American Medical Association and other physician groups have met with the FBI and Justice Department to ensure that the highest law enforcement agencies in the US are doing everything in their power to protect physicians against terrorists. AMA also formed a 20-person crisis team to call the 225 physicians listed on an anti-abortion web site as either "working," "wounded," or "fatality." AMA provided these physicians with contact phone numbers at appropriate law enforcement agencies.

These activities are part of AMA's ongoing efforts to protect physicians' rights to practice high quality medicine on behalf of their patients. AMA has also taken action on behalf of biomedical researchers targeted by an extreme faction of "animal rights activists" as well as those at risk in hospitals, especially emergency departments.

HCFA Proposes New Medicare Payment Rule

The Health Care Financing Administration has proposed a new Medicare payment system that will raise payments to office-based physicians while lowering them to physicians who practice primarily in hospitals. The new system will be phased in over a four-year period.

Billing Practices Differ for Non-Credentialed Physicians

Many health plans do not allow practices to bill for the services of physicians who have not yet been credentialed by the plan. Some health plans allow practices to bill for the services performed by a non-credentialed physician once the credentialing process is complete. Other plans, however, do not allow practices to bill for physician services unless the service is performed by a physician who is already credentialed. Check with each plan to find out its policy on this issue.

Black Physicians Oppose the Legalization of Marijuana for "Medical" Purposes through Ballot Initiative

According to a recent report from the National Medical Association (NMA), the medical society representing over 20,000 African American physicians dedicated to promoting quality healthcare for all Americans, opposes the legalization of marijuana for "medical" purposes through a ballot initiative.

The report states, "Legalization of marijuana for 'medical' purposes presents serious problems to the American public because science has not proven marijuana to be a legitimate medicine. Also, purity and proper dosage has not been determined and public health may be sacrificed by utilizing the ballot box rather than the scientific process to determine safe and effective medicine.

"There is FDA approved medication, Dronabinol, that contains the active ingredient (THC) contained in marijuana which can be prescribed to treat the same conditions that smoked marijuana is used for. It has been tested for its purity and is available to doctors to prescribe in measurable doses. Further, the National Institutes of Health and the Food and Drug Administration must be involved in the testing for the effectiveness and safety of marijuana in other potential medical treatments."

According to NMA President, Gary C. Dennis, MD, "Science, not politics, must determine what is safe and effective medicine in America."

Procedure May Keep Arteries From Re-Clogging After Angioplasty

University of Louisville physicians at Jewish Hospital have begun testing a procedure that could reduce the need for repeat angioplasty, heart bypass surgery, and other cardiac treatments.

The experimental Beta-Cath system holds promise for patients whose arteries reclog after they undergo balloon angioplasty or stent placement, said **Massoud Leesar, MD**, an assistant professor of medicine at U of L who is overseeing the test.

Balloon angioplasty often injures artery walls, prompting the growth of scar tissue which reblocks the artery, Dr Leesar said.

Sometimes physicians implant expandable metal devices called stents that support the artery walls, but they can irritate artery walls, which can result in relogging, he said. According to Dr Leesar, the Beta-Cath system, which uses beta radiation to curb the growth of scar tissue, takes less than 30 minutes and carries no known additional risks. The new treatment is being given to half of the participants in the test, with the other half receiving a placebo.

Laboratory results and a small study at Emory University showed that Beta-Cath reduced relogging after balloon angioplasty to 14%, while patients who received a placebo had a relogging rate of 42%.

Louisville is the only site in Kentucky for the test, and one of only 22 nationwide, Dr Leesar said.

AMA Launches Education for Patient End-Of-Life Care

A new AMA initiative to improve the care of dying patients nationwide was given unanimous support by the KMA House of Delegates at its 1998 meeting. EPEC — Education for Patient End-Of-Life Care — is an innovative, long-term program of the AMA's Institute for Ethics, intended to reach all practicing physicians within the next 2 years.

EPEC will use a "train-the-trainer" model and will be hosted at national and regional workshops beginning in early 1999. The curriculum addresses issues such as:

- Treating the common symptoms of dying patients;
- Making decisions about life-sustaining treatment;
- Delivering the news of a life-threatening diagnosis;
- Conducting a basic patient assessment in end-of-life care;
- Managing imminent dying and bereavement;
- Handling prognostic uncertainty; and
- Approaching futility situations.

In addition, AMA is developing a speakers list, resource guide, compendium of hospice and palliative care sites, and a monograph of the training curriculum. For information on workshops or other resources, contact the AMA at 312/464.4979.

"Microwaving" Tumors May Improve Liver Cancer Treatment

Liver cancer patients often face lengthy surgery, serious complications, and long recovery times. A procedure being tested at the University of Louisville may eliminate some of these problems.

Surgeons are testing a small probe, which is inserted into the liver. Once they've located the tumor, the surgeons deploy from the probe small tines that surround the cancerous growth. Using microwave energy, the surgeons heat the tines, killing the tumor.

Oncologist **Kelly M. McMaster, MD**, says the technique has cut hospital stays from 2 weeks to 4 days and may shorten them more in the future.

Medicaid Managed Care Official Outlines Successes, Problems

In testimony before a state legislative committee, Joyce Hagen Schifano, Executive Director of the Louisville Medicaid Managed Care Program, outlined what she saw as the successes and problems experienced by the program during its first year of operation. The successes include a new "mommy and me" program in which nurses work closely with expectant mothers throughout their pregnancies; a new case management program; a 24-hour nurse line for recipients; and a good working relationship with

the state. The problems outlined by Ms Schifano include overall frustration with the change in the program; too much of the program being run out of Pennsylvania where the third-party administrator is headquartered; the program's \$10 million cost overrun; and problems with determining recipient eligibility.

Physician Management Companies Suffer Financially

Rumors that publicly traded PhyCor, Inc may go private have been denied, although the company's stock has plummeted because of lowering its earnings forecasts throughout the year. Meanwhile, the nation's largest physician management company, MedPartners, Inc, is getting out of the physician management business by shedding its 238 physician clinics and more than 13,000 affiliated physicians. The company, which is \$1.7 billion in debt, will concentrate on its pharmacy benefits business.

Nerve Stimulator Helps in Treating Epilepsy

A University of Louisville neurosurgeon is using nerve stimulation to help reduce the effects of epileptic seizures.

Dante J. Morassutti, MD, implants an electronic nerve stimulator in some epileptic patients. Every five minutes, the computerized device delivers a 30-second burst of electricity to the vagus nerve, which carries a low-voltage current to the brain.

The stimulator is programmed by neurologist **Michael Gruenthal, MD**, director of U of L's Epilepsy Program.

The treatment has helped reduce the frequency and severity of seizures in some patients.

Transplant Center Marks Milestone

U of L professor and Jewish Hospital surgeon **Frederick R. Bentley, MD**, performed a milestone procedure October 15, 1998 — the Transplant Center's 2000th transplant.

The Transplant Center, a program of the U of L medical school and Jewish Hospital, is home to many of the state's "firsts."

The center's surgeons performed Kentucky's first kidney transplant (1964); the first heart transplant (1984); the first kidney/pancreas transplant (1987); the first pancreas-only transplant (1987); the first heart/lung transplant (1991); and the first double-lung transplant (1995).

Dr Bentley recently performed two other milestone procedures — the state's first two laparoscopic nephrectomies. The procedure involves retrieving a donated kidney from a living donor through small incisions using miniature videoscopic equipment.

"This procedure is a positive development for living-donor kidney transplants," Dr Bentley said. "The traditional nephrectomy required that the donor be off work for 4 to 6 weeks, making donation too

impractical for many. Now donors can be back to work in 2 to 3 weeks, knowing that they've helped save the life of a friend or loved one."

Both procedures were performed at the Transplant Center.



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Preparation — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.

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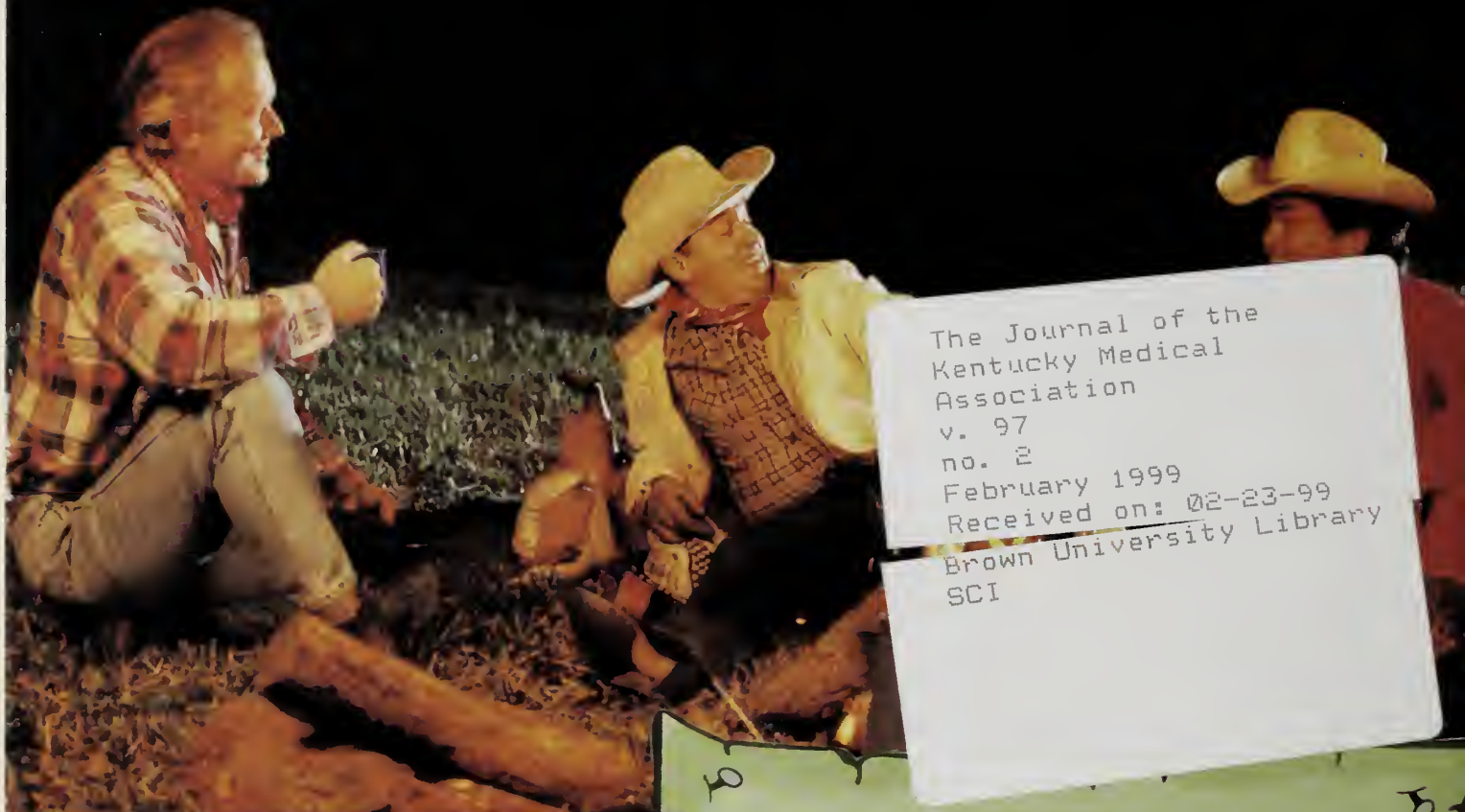
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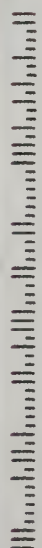
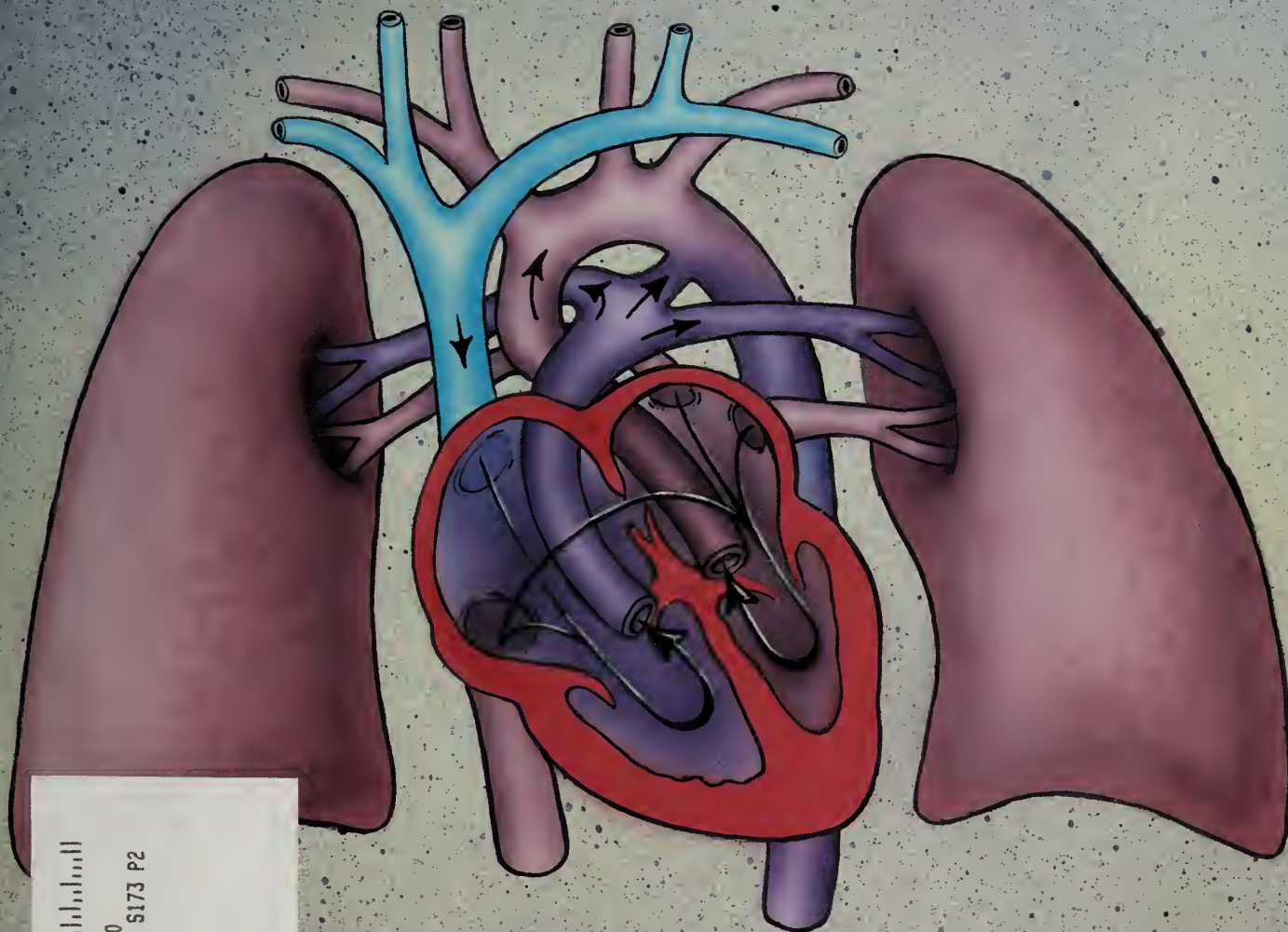
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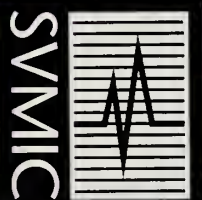
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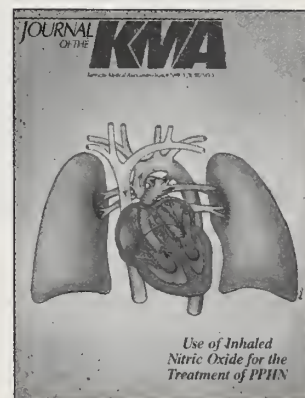
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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Periodical postage paid at Louisville, KY and additional offices. Yearly subscription rates: \$35 domestic; \$45 foreign. Single issues \$4 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222. Telephone 502/426-6200; Fax 502/426-6877.

Listed in *Index Medicus*. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

EDITORIAL AND ADVERTISING:
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Printed by the Ovid Bell Press, Inc, Fulton, Missouri 65251.

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Kentucky Medical Association

CERTIFICATE OF NEED REDUX, ONCE AGAIN, OVER AND OVER



The KMA Board of Trustees reaffirms and endorses the retention of the Certificate of Need Law with an option of reviewing modifications as periodically proposed. The KMA continues to support the preservation of the private physician's office exemption.

So, that is our policy. But, questions keep recurring. Most recently State Representative Harry Moberly, Jr (Madison Co) has requested a legal opinion from the Attorney General regarding CON. The Attorney General's office referred Representative Moberly's query to the KMA. The KMA Quick Action Committee has responded by citing the above stated KMA policy which was most recently affirmed by the 1997 KMA House of Delegates.

The CON issue has been dealt with in at least five House of Delegates sessions. The House of Delegates has consistently opposed any changes in the CON law which would allow regulatory intrusion into physicians' offices. Yet, the waves continue to beat against the barrier, generated by the state and by the Kentucky Hospital Association. The KHA remains strongly supportive of CON and has proposed that it should apply to physicians' offices in certain circumstances including: ambulatory surgery performed under general anesthesia, MRI, radiation therapy, cardiac catheterization, open heart surgery, inpatient services, and organ transplants.

For physicians the discussion divides along several lines: rural vs urban, generalist vs specialists, small practice vs large group. If a large facility is developed in a rural area, what is the effect on the local hospital? Is this just as problematic for urban hospitals? If a

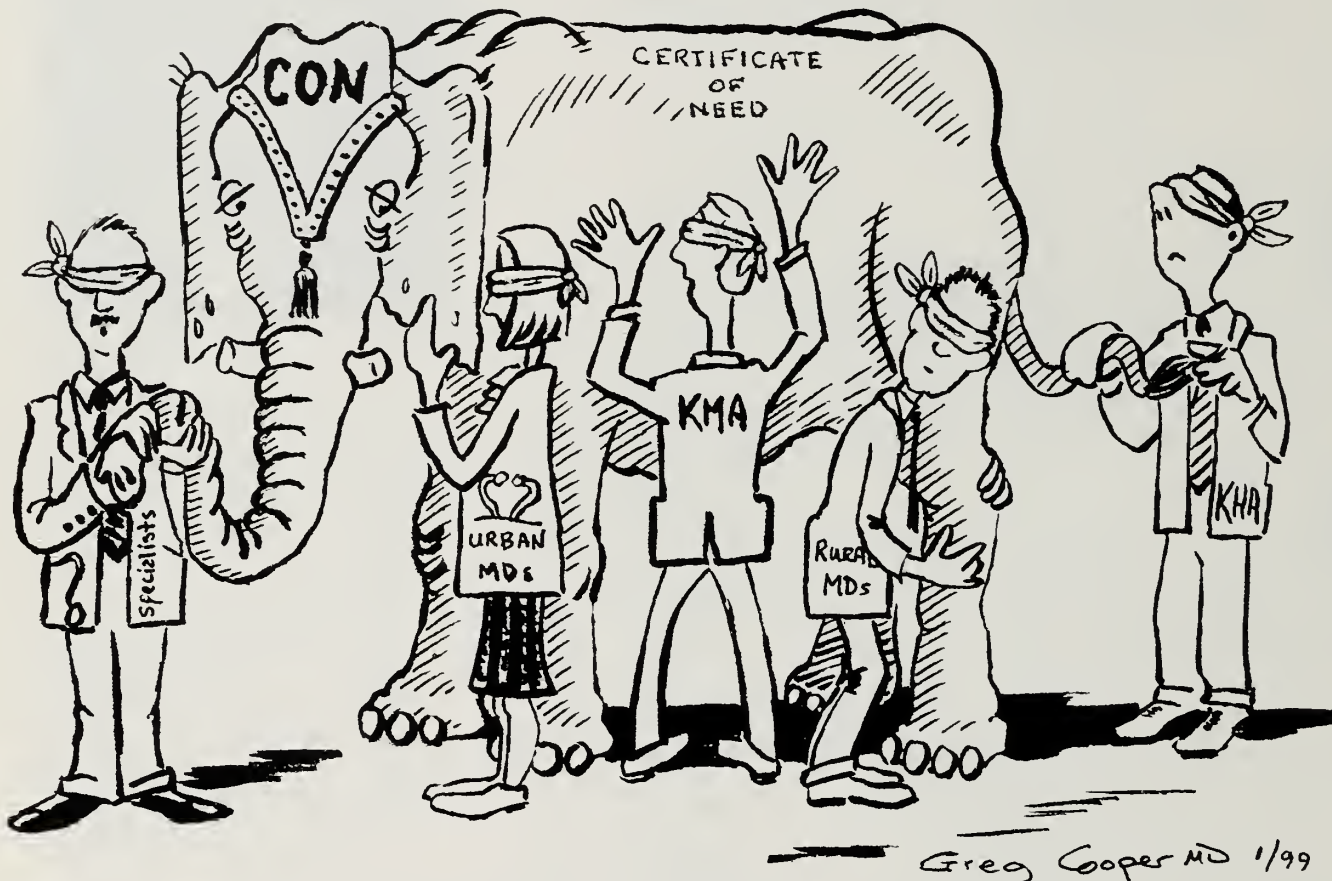
large group wants to establish an outpatient facility should CON apply? What about licensure? What about reimbursement?

Managed Care has impacted CON issues. According to a report entitled *Certificate of Need in Kentucky*, prepared for the state Subcommittee on Health Care Access and Cost Oversight, June 12, 1997, "As managed care continues to develop in Kentucky and works to promote competition and cost containment, the usefulness of CON for certain services will be limited at best."

Many states function without CON. BNA's *Health Law Reporter* in a September 25, 1997, article stated the following:

The trend while sometimes overstated, is clear. Certificate-of-need (CON) laws, originally intended to bring health care costs under control by preventing facilities from expanding unnecessarily, have been abolished in 13 states and whittled back to a shell in others. Thirty-seven states and the District of Columbia still have CON laws in some form, but they range from broad regulation in Maine, Connecticut, and West Virginia to nearly nothing in states like Louisiana . . .

The CON issue has been dealt with in at least five House of Delegates sessions. The House of Delegates has consistently opposed any changes in the CON law which would allow regulatory intrusion into physician's offices.



"IF WE CAN'T IDENTIFY THIS CREATURE, SHOULD WE TRY TO KILL IT?"

Obviously we need to look closely at the experiences of other states as we consider our own CON issues.

I did not mean this article to be a rehash of the CON article which appeared in the *Journal of the KMA* this January (Vol 97, No 1), but I can assure our members that this won't be the last time you will hear these issues discussed. As Chairman of the Board I want

to make sure that the membership of the KMA is fully aware that this discussion is ongoing. The Board welcomes any opinions and input that may help us protect our practices as we strive to give our patients the care they deserve.

J. Gregory Cooper, MD
Chair, Board of Trustees

MONITORING Medicine

NEWS FOR KENTUCKY PHYSICIANS

Health Debates Heat Up

How do we encourage more insurance companies to write policies in Kentucky? How do we guarantee coverage for Kentucky's extremely ill and indigent citizens? How do we save the County Health Departments? Can the Medicaid Managed Care Partnerships work?

These are just a few of the questions legislators on the

Banking & Insurance and Health & Welfare committees were asking in January as they began their 1999 Interim Committee Meetings. Their deliberations in the Interim will likely determine the health care and health insurance agendas for the 2000 General Assembly. Eleven months before the next regular session, those agendas already appear full.

Partnerships vs Health Departments

A legislative battle forming in the Health & Welfare Interim Committee is how to maintain revenues to County Health Departments as the Medicaid Managed Care Partnerships are implemented—if and when that occurs. The groundwork for this battle was laid in the January Health & Welfare meeting when Dr Rice Leach, Commissioner of Public Health, testified before the committee.

In his report about the state of public health in Kentucky, Dr Leach indicated that the financial

outlook of the health departments was not good. When asked by a legislator whether the new Medicaid system contributed to that outlook, Dr Leach responded yes, but that additional factors play a role. At that point, several legislators took the opportunity to express the importance of the health departments in their districts. A few legislators went so far as to say that they would rather see health departments succeed even at the expense of the partnerships.

MONITORING Medicine

Out of State Insurance Exec Testifies

In his comments during the Health & Welfare meeting, Senator Scorsone (D, Lexington) expressed concern about care for the indigent and introduced a resolution calling for preservation of the role of health departments in caring for the poor—it passed. Senator Scorsone also called for a meeting with Governor Patton about the issue and held a press conference the following day in front of the Lexington-Fayette County Health Department. At the press conference, he claimed the new Medicaid system, which allocates Medicaid dollars to primary care physicians through the partnerships, was causing the state's health departments to stretch their dollars by cutting services and staff, thereby reducing care for the indigent.

At the request of Representative Ron Crimm (R, Louisville), Steve Puck, Sr Vice President, Legal Affairs, with CERES, Inc—an insurance company that quit writing policies in Kentucky after the passage of House Bill 250 in 1994—testified before the Interim Committee on Banking & Insurance in January. Representative Crimm asked Mr Puck to share with the committee why his company had not returned to the Kentucky insurance market since the passage of House Bill 315 in 1998. In his comments, Mr Puck offered six reasons why CERES had not returned to the Kentucky market. They are:

1. The uncertainty of the risk adjustment process in Kentucky
2. The mechanism used to insure high risk and indigent individuals (GAP or Guaranteed Acceptance Program)
3. Premium rate increase maximums adopted in House Bill 315 at a 5-1 ratio
4. The additional rate approval process required in Kentucky
5. State mandated coverages

6. Additional administrative expenses for doing business in Kentucky like collecting taxes for local municipalities.

Following his comments, Mr Puck fielded questions and listened to comments from legislators about House Bill 315. Many of the comments originated from Representative Bob Damron (D, Nicholasville), a co-author of House Bill 315 with Representative Bob DeWeese, MD (R, Louisville), who clarified what he thought were several misstatements in Mr Puck's testimony. Other legislators joined Representative Damron in questioning the insurance executive's understanding of the bill. That prompted Senator Dick Roeding (R, Villa Hills) to say that the committee should not berate Mr Puck, but welcome his and other insurance executives' testimony because they hold the key to increasing competition in Kentucky's insurance market.

While legislators serving on Banking & Insurance agreed with Senator Roeding, that Steve Puck's testimony was helpful, they may have set the stage for additional health insurance debate in the months leading up

MONITORING **Medicine**

Alternative Health Task Force Meets

to the 2000 General Assembly. In fact, the committee reappointed a Subcommittee on Health Insurance, which is chaired by Representative Jim Gooch (D, Providence), to begin deliberations on the issue as soon as possible.

In its January meeting, the Task Force on Alternative Health met to hear testimony on aroma, herbal, and energy transfer (touch) therapies. The task force, comprised of legislative and citizen members—including physicians, plans to hear additional testimony in February and March on other alternative

therapies as well as from individuals who profess success or failure from trying such treatments. Representative Tom Burch (D, Louisville), who chairs the task force, indicated he would like the group to begin drafting legislation in April that will be introduced next year in the legislative session.

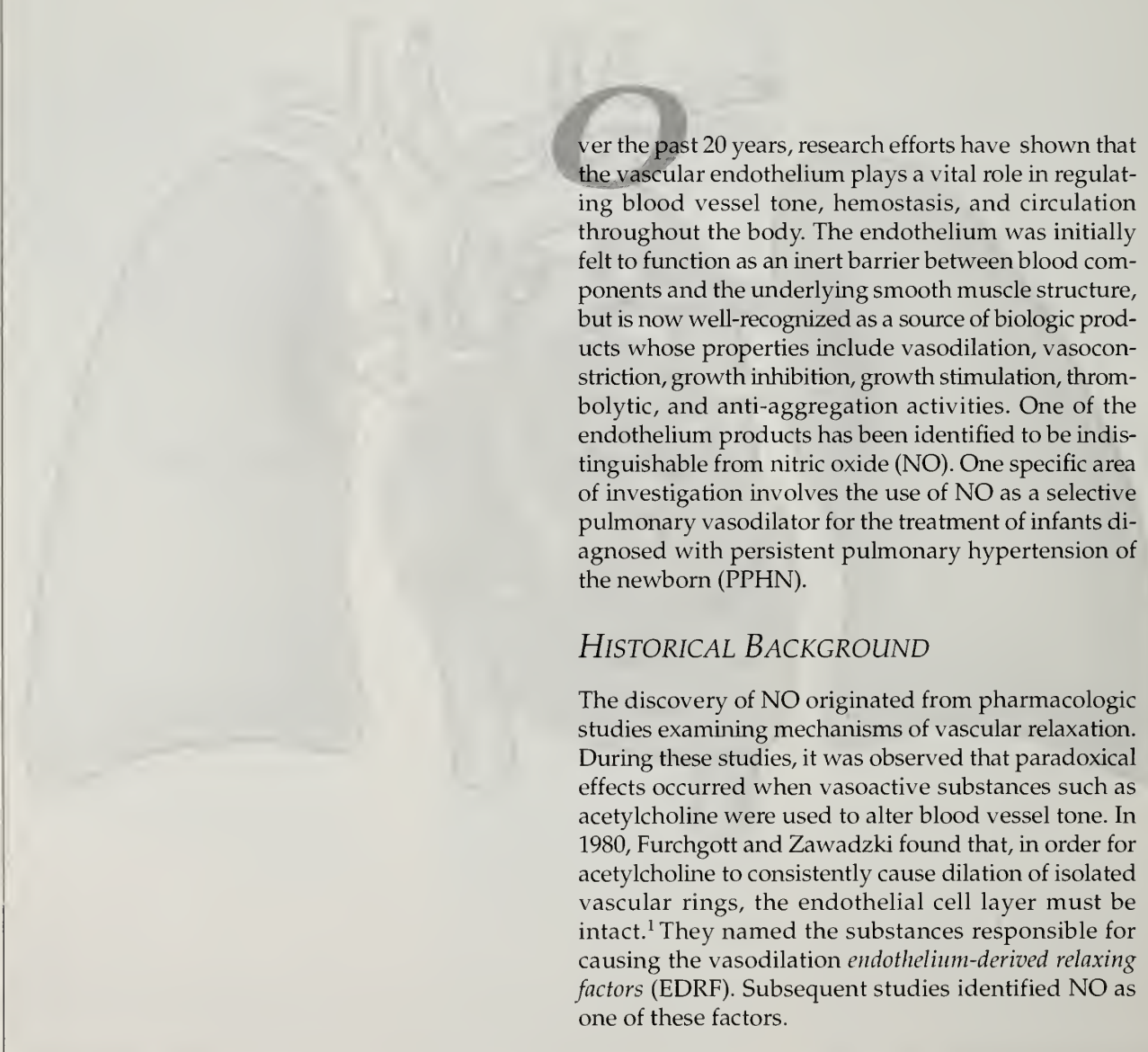
Other Health Topics for 2000

In addition to the topics covered in this article, legislators and state officials are also struggling with the highly publicized problems with K-CHIP (Kentucky Children's Health Initiative Program), the closing and revenue shortfalls of Kentucky KARE (the state employees' health insurance fund), and the subsequent dilemma of

providing insurance coverage to state employees. With these health issues and others that may pop up before January 2000, it appears legislators will spend much of their first session in the new millennium on how to provide Kentuckians with access to quality and cost-effective health care.

USE OF INHALED NITRIC OXIDE FOR THE TREATMENT OF PERSISTENT PULMONARY HYPERTENSION OF THE NEWBORN (PPHN)

Tonya Robinson, MD; Dan L. Stewart, MD; Tony Hilbert, RRT



Over the past 20 years, research efforts have shown that the vascular endothelium plays a vital role in regulating blood vessel tone, hemostasis, and circulation throughout the body. The endothelium was initially felt to function as an inert barrier between blood components and the underlying smooth muscle structure, but is now well-recognized as a source of biologic products whose properties include vasodilation, vasoconstriction, growth inhibition, growth stimulation, thrombolytic, and anti-aggregation activities. One of the endothelium products has been identified to be indistinguishable from nitric oxide (NO). One specific area of investigation involves the use of NO as a selective pulmonary vasodilator for the treatment of infants diagnosed with persistent pulmonary hypertension of the newborn (PPHN).

HISTORICAL BACKGROUND

The discovery of NO originated from pharmacologic studies examining mechanisms of vascular relaxation. During these studies, it was observed that paradoxical effects occurred when vasoactive substances such as acetylcholine were used to alter blood vessel tone. In 1980, Furchgott and Zawadzki found that, in order for acetylcholine to consistently cause dilation of isolated vascular rings, the endothelial cell layer must be intact.¹ They named the substances responsible for causing the vasodilation *endothelium-derived relaxing factors* (EDRF). Subsequent studies identified NO as one of these factors.

PHYSIOLOGY OF NITRIC OXIDE

Endogenous NO is synthesized in the vascular endothelial cell from L-arginine by nitric synthase. Since it is lipophilic, it readily diffuses into the adjacent vascular smooth muscle cell and binds to soluble guanylate cyclase. The activated guanylate cyclase allows for the production of guanosine 3'5'-cyclic monophosphate (cGMP), which mediates vasodilation. Control over this vasodilation is mediated, in part, by the enzyme, cGMP phosphodiesterase, which inactivates the guanylate cyclase.² When exposed to the circulation, NO lacks systemic effects because it is rapidly inactivated as it binds to hemoglobin. Systemic effects are further limited since NO has a half-life of only 3 to 5 seconds. Both animal and human studies have shown that inhaled NO selectively reduces elevated pulmonary pressure and decreases vessel tone without causing systemic circulatory complications.

Fetal and perinatal animal studies have determined that the capacity for the endothelial cell to release NO increases with gestational age and that NO has a major role in provoking the pulmonary vasodilation that occurs during the transition from fetal to extrauterine cardiopulmonary circulation. In newborn lambs subjected to hypoxia and respiratory acidosis, it has been observed that inhaled NO can cause selective pulmonary vasodilation. As a result, it was proposed that neonatal lung disease with disrupted pulmonary vascular tone, such as PPHN, may be associated with abnormal endothelial cell function and, thus, might benefit from inhaled NO therapy.

Case Presentation

The following case exemplifies a beneficial response to NO therapy by an infant diagnosed with PPHN due to meconium aspiration.

CASE: This 4690 gram birth weight term female infant was born to a 26 year old gravida 1, para 0, white female via emergent cesarean section secondary to failure to progress and non-reassuring heart rate tracings. The only known complication of the pregnancy was maternal hy-

pertension. There had been no recent maternal illness or fever and the mother did not receive antibiotics prior to delivery. Rupture of membranes with particulate meconium stained amniotic fluid occurred just before delivery. The umbilical cord was wrapped around the infant's neck twice. The infant was described as limp with poor respiratory effort, but with a heart rate greater than 100 beats/minute. She was intubated with a 10 French catheter and 2 cc of thick meconium stained fluid were suctioned from below the vocal cords. Positive pressure ventilation with 100% oxygen was administered for 2 minutes. Due to poor response, the infant was intubated. Apgar scores were 3 at 1 and 5 minutes and 4 at 10 and 15 minutes of life. By the time the infant was transferred from labor and delivery to the neonatal intensive care unit, she was active, making spontaneous respiratory efforts, with coarse bilateral rhonci and marked intercostal retractions.

The initial chest x-ray revealed extensive patchy bilateral pulmonary infiltrates consistent with meconium aspiration. The infant was initially started on conventional positive pressure, time-cycled ventilation; however, because of escalating requirements to maintain acceptable oxygenation, the infant was changed to high frequency oscillatory ventilation. Unfortunately, even with mean airway pressures up to 20 mmHg, the best PaO₂ achieved was 54 mmHg with an oxygen index (OI) of 37. ($OI = (FiO_2 \times MAP \times 100) / PaO_2$). An OI of > 15 signifies severe respiratory compromise while an OI of ≥ 40 is associated with a mortality risk approaching 80%.) An echocardiogram obtained at that time was consistent with moderate pulmonary hypertension with a right ventricular pressure of 75 mmHg.

In light of the infant's deterioration, a trial of NO was attempted before proceeding with extracorporeal membrane oxygenation (ECMO). Within 20 minutes following the initiation of NO, the PaO₂ increased from 54 mmHg to 219 mmHg

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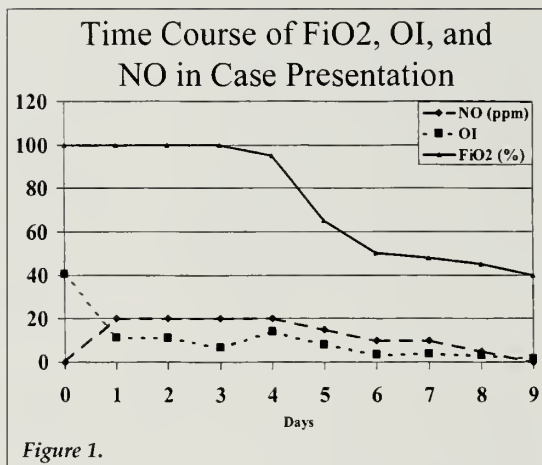


Figure 1.

without changing ventilator settings. Figure 1 displays the time course of the OI, and the concentrations of NO and FiO₂ before and during NO administration.

Follow-up echocardiogram studies obtained 24 and 72 hours after initiating NO showed right ventricular pressures had decreased to 55 mmHg and 45 mmHg respectively. After 6 days of therapy, the infant was weaned from NO and converted back to conventional ventilator support. She was extubated after a total of 11 days of mechanical ventilation and was discharged home on room air at 23 days of age. At 6 months of age the infant is neurodevelopmentally normal. She has remained healthy and has not required subsequent hospitalization or experienced adverse respiratory symptoms.

CLINICAL APPLICATION OF NITRIC OXIDE

PPHN involves failure of the newborn to successfully make the cardiopulmonary adaptation from fetal to neonatal circulation (see Figures 2 and 3). After birth, pulmonary vascular resistance (PVR) normally decreases rapidly to enhance pulmonary blood flow, ventilation, and oxygenation. PVR is directly reduced by shear stress on the endothelium resulting from augmented pulmonary blood flow, clearance of fetal lung fluid, and improved gas exchange within the lung. These birth-related events modulate pulmonary vascular tone, in part, by re-

leasing vasodilating substances (ie, bradykinin, prostacyclin, adenosine, endogenous NO) and/or inhibiting vasoconstricting substances (ie, leukotrienes, endothelins). In PPHN, the normal decline in PVR does not occur. Since PVR fails to fall, blood flow is shunted right to left across the patent ductus arteriosus and patent foramen ovale, causing severe hypoxemia, myocardial dysfunction, and hypotension.

As a clinical syndrome, PPHN is associated with numerous cardiopulmonary disorders such as asphyxia, respiratory distress syndrome, lung hypoplasia, congenital diaphragmatic hernia, meconium aspiration syndrome, pneumonia, and sepsis, all of which have abnormally elevated pulmonary pressures. Clinical management of infants with PPHN has been devoted to reduction of the high PVR associated with PPHN. Since respiratory alkalosis is known to lower PVR, hyperventilation has been one of the primary treatment strategies for PPHN. This tactic carries a significant risk of inducing morbid barotrauma to the lungs and adversely altering blood flow to the brain. Pharmacologic therapies involving various vasodilators such as sodium nitroprusside, prostaglandin E₁, and tolazoline have also been used in the treatment of PPHN. Clinical responses to these substances have been unpredictable and have involved side effects that may contribute to the disease course. These substances not only reduce PVR, but can also induce systemic vasodilation, hypotension, and hypoxemia. Current strategies for the treatment of PPHN include high-frequency ventilation, extracorporeal membrane oxygenation (ECMO), surfactant administration and, recently, inhaled NO.

Inhaled NO is delivered through the ventilator circuit to infants diagnosed with PPHN. As a gas, NO is blended with nitrogen and oxygen until the desired concentration of each gas is achieved. Once the gases are exhaled by the infant, they are scavenged by wall suction. When the infant has weaned sufficiently on mechanical ventilation to minimize barotrauma, the NO concentration is slowly reduced and then discontinued. Many studies have now been performed that support the use of NO in the treatment of some patients with PPHN.

RESEARCH STUDIES

In 1992, Roberts et al published their findings that inhaled NO (80 ppm) for 30 minute intervals improved oxygenation in 6 infants diagnosed with severe PPHN.³ During that same year, Kinsella et al demonstrated a lower dose of inhaled NO (6 to 20 ppm) improved oxygenation enough to avoid the need for ECMO in 8 of 9 infants with severe PPHN.⁴ Follow-up studies by Kinsella, as well as dose response studies by Finer et al, confirmed that lower doses of inhaled NO in the range of 5 to 20 ppm are as effective as high doses (80 ppm) in the treatment of infants with PPHN.^{4,5}

Poor responses to inhaled NO have been studied extensively. Patients with the greatest response to inhaled NO have echocardiographic evidence of pulmonary hypertension. To be effective, inhaled NO must be adequately delivered to the terminal airways where it can diffuse into the adjacent smooth muscle and provoke vasodilation. A poor response to NO therapy may reflect alterations in pulmonary mechanics, diminished alveolar ventilation, and/or limited dispersion of the inhaled NO. There is a significant correlation between functional reserve capacity (FRC) and responses to NO that indicates responders have a significantly greater FRC than nonresponders. Ventilatory strategies that optimize lung volume and use of exogenous surfactant therapy to enhance FRC may improve the response to NO. A poor response to NO therapy has also been observed in patients with sepsis, myocardial dysfunction, and severe hypertensive vascular remodeling.

Adverse side effects to inhaled NO have been the focus of a number of studies. It is well documented that NO rapidly binds to hemoglobin to form nitrosylhemoglobin, which is then quickly converted to methemoglobin. Under normal circumstances, methemoglobin is reduced by the erythrocyte-derived enzyme, methemoglobin reductase. If, however, concentrations exceed the ability of the erythrocytes to metabolize the methemoglobin, dangerous levels can occur, resulting in decreased oxygen carrying capacity and hypoxia. Only insignificant amounts of methemoglobin (<3%) have been

Figure 2. Adaptation of Cardiopulmonary Physiology After Birth

Structure	Function Before Birth (Fetal)	Function After Birth (Neonatal)
Placenta	Oxygen and carbon dioxide exchange.	Eliminated from circulation and gas exchange assumed by lungs.
Foramen Ovale	Connects right and left atria. Shunts oxygenated blood from right atrium to left atrium so as to bypass right ventricle and pulmonary circulation.	Closes after birth so as to direct unoxygenated blood from right atrium to the right ventricle and then to the pulmonary circulation.
Lungs	Uninflated, minimal pulmonary blood flow and increased pulmonary vascular resistance (PVR).	Increased pulmonary blood flow and decreased PVR. Active in gas exchange.
Ductus Arteriosus	Bypasses blood flow from the lungs into the descending aorta.	Closes after birth and once it is obliterated, forms the ligamentum arteriosum. Blood flow circulates directly to lungs.
Aorta	Receives mixture of oxygenated and non-oxygenated blood from the pulmonary artery via the ductus arteriosus and from the left ventricle.	Receives only oxygenated blood from the left ventricle.

Diagram: Fetal Circulation

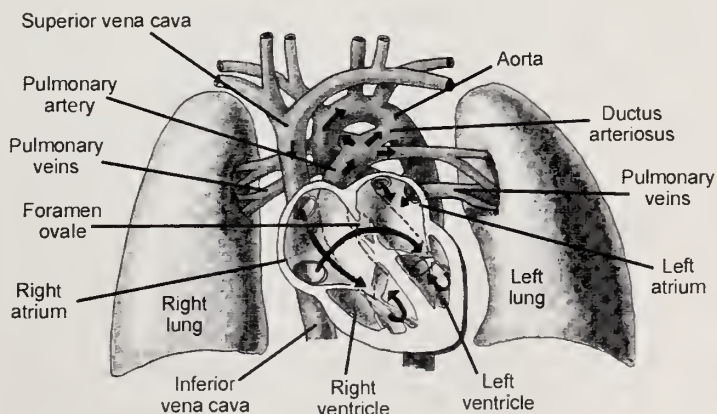


Figure 3.

documented when < 20 ppm of NO has been used with exposures greater than 24 hours. One patient was reportedly exposed to high doses of NO for greater than 53 days and had a maximum methemoglobin level of only 1.3%.⁶ Lung injury resulting from NO and its metabolites has also been a major focus of a number of investigations. *In vitro* studies using high concentrations of NO and its oxidized product, NO₂, are known to cause epithelial cell injury, lipid peroxidation, and alteration of surfactant proteins.⁷ Whether these changes are present *in vivo* and/or can explain poor responses to inhaled NO is still unclear. Animal studies using up to 1500 ppm of NO for 15 minutes or 1000 ppm for 30 minutes failed to show histopathologic changes of the lungs at autopsy.⁷ On the other hand, Stephens et al observed lung injury in humans exposed to 72 hours of NO (17 ppm) and 5 hours of NO₂ (2.3 ppm).⁸ The National Institute for Occupational Health has established that the limits for exposure in an 8-hour day are 25 ppm for NO and 5 ppm for NO₂.⁹ Of note is the fact that cigarette smoke has an extremely high concentration of NO and can approach 1000 ppm. It is imperative that any protocol involving the administration of inhaled NO should include monitoring NO and NO₂ levels. During the administration of inhaled NO for the treatment of infants diagnosed with PPHN, concentrations of NO and NO₂ are continuously monitored through a side-port of the ventilator circuit. When levels are regulated, low concentrations of inhaled NO have not been observed to cause adverse effects in infants or adults. Meta-analysis of eight randomized controlled trials evaluating the use of NO has provided evidence that NO can significantly improve oxygenation, decrease the oxygenation index, lessen the need for ECMO, and reduce the incidence of death when compared to controls.¹⁰ The incidence of death or need for more invasive therapeutic measures, such as ECMO, was significantly reduced in the NO treated group with a relative risk of 0.71 compared to control (95% CI, 0.57, 0.87).¹⁰ Long-term follow-up of infants who have received NO is still needed in order to ascertain conclusively the safety and benefit of NO in the treatment of PPHN.

CONCLUSION

Inhaled NO appears to be a promising therapy for the treatment of PPHN. It has an advantage over most pharmacologic therapies tried with this disease because it can lower PVR without affecting the systemic vascular resistance. It has been shown to improve oxygenation in some patients that would otherwise have required more invasive therapies. Unfortunately, there exists a population of patients who are persistently refractory to NO. Further studies are needed to develop strategies that optimize the use of NO in the treatment of infants with respiratory disorders characterized by pulmonary hypertension and how to use it effectively with other therapies such as surfactant, liquid ventilation, high frequency ventilation, and ECMO.

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ABSORBABLE FASTENERS FOR THE FIXATION OF ANKLE FRACTURES

Kittie George, MD; Dr.med. Dietrich Becker; David Seligson, MD

Bioabsorbable materials have been used for the treatment of fractures for more than a century. We reviewed the results of a combined series of 30 ankle fractures from Bad Hersfeld, Germany, and Louisville, Kentucky, using initially polyglycolide and more recently poly-L-lactide screws and rods. The results were comparable to treatment with metal screws. The advantage of bioabsorbable implants is they do not need operations to take them out. There was a low incidence of reaction around the screw heads, which was reduced further with the use of the newer self-reinforced poly-L-lactate screws. The technique for use of plastics is different than the methods for placement of metal screws. Bioabsorbables will have an increasing role in fracture fixation in the future.

the improved self-reinforced PLLA rods and screws for fracture surgery.

Since our most common indication for absorbable fasteners is fractures of the ankle, we therefore want to report on our first 30 cases of ankle fractures treated in Bad Hersfeld and Louisville.

From the Department of Orthopedics, University of Louisville (Dr George, Resident; Dr Seligson, Professor & Vice Chair), and Oberarzt Unfallchirurgie Klinik, Akad Krankenhauses Bad Hersfeld (Dr Becker).

MATERIALS AND METHODS

The 30 patients ranged in age from 12 to 84 years with a median age of 44. There were 11 men and 19 women. In total we used 51 bioabsorbable implants for treatment of these ankle fractures. Thirty-eight implants were used on the medial side where they were used for fixation of medial malleolus fractures. Thirteen implants were used on the lateral side where they were used for fixation of the fibula (Figure 2) or for fixation of the distal tibia-fibular (Figure 3). Initially PGA im-

The idea of using absorbable materials for fracture fixation was initially introduced in the late 1800s when Nicholas Senn proposed the use of absorbable materials such as cylinders made from the long bones of turkeys, chickens, and rabbits, as well as ferrules made from sections of ox bone.²

Modern absorbable devices are made of synthetic polymer materials such as polyglycolide (PGA) and poly-L-lactate (PLLA) (Figure 1). Polylactic acid has surpassed PGA as the polymer of choice for these implants because its degradation time is considerably longer.³ Both polymers are ductile, have high initial strength, appropriate elasticity modulus, good torsional strength, are totally absorbable, and lose their strength gradually.⁵

Our initial experience at the University of Louisville was with a polylactide screw in the treatment of closed, displaced ankle fractures. Clinical results were satisfactory, but handling properties of the screw were poor.¹ Encouraged by an experience in Bad Hersfeld, Germany, of 5 years with more than 100 metaphyseal fractures successfully treated with absorbable PGA rods, we have taken a second look at the use of

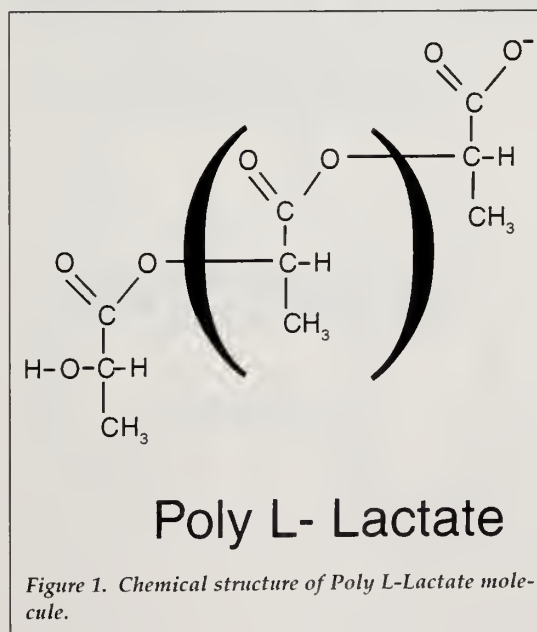




Figure 2a. Pre Operative Radiograph



Figure 2c. Post Operative Radiograph.

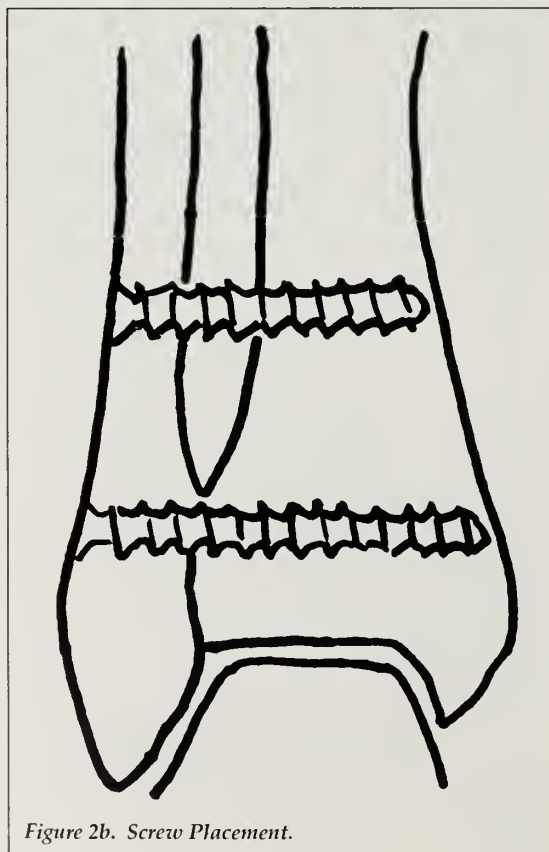


Figure 2b. Screw Placement.

plants were used. Subsequently PLLA screws and pins were placed.

RESULTS

The results with plastic PLLA screws have been good. Clinically they are the same as with metal implants. There is, however, a learning curve as these fasteners are not the same as metal fasteners for the treatment of ankle fractures. It takes some adjustment to review postoperative films that do not show the implants.

In our experience we recommend standard open reduction techniques and temporary fixation with Kirschner wires (K-wires). Unlike a metal screw, it is difficult to remove a plastic screw once it has been inserted. Therefore, it can be hard to use two screws in combination since they cannot be repositioned once they are inserted. One solution is to first do a good reduction, hold this in place with K-wires, then drill the correct hole for the root of the screw, tap with the appropriate tap, insert the screw, remove one of the remaining K-wires, and place an anti-rotation pin. The pins are oval in cross-section so they seize in the hole and get good purchase.



Figure 3a. Pre Operative Radiograph of a right bi-malleolar ankle fracture.

In this combined case series we encountered seven complications. The most common complication was a soft tissue reaction around the screw head. This occurred in four early cases treated with PGA implants and subsided with decreased activity and oral antibiotics. In three cases the fastener did not maintain the reduction and subsequently the ankle had to be re-reduced and treated with a cast and mobilization.

DISCUSSION

Absorbable implants have been in use in Finland for two decades. Rokkanen et al studied 2,500 patients that were managed using bone fixation devices made of absorbable material.⁵ The reported complications and complication rate were similar to those reported with metal implants.

The incidence of symptoms relating to retained metal implants in patients with healed fractures varies widely. Reported symptoms re-



Figure 3b. Post Operative Radiograph with a 3.5 mm bioabsorbable screw and 1.5 mm absorbable pin placed in the medial malleolus, as well as (2) 2.0 mm bioabsorbable pins placed in the lateral malleolus.

lated to implants have ranged from formation of bursae over the implants, local tissue reaction (either of allergic or chronic inflammatory type) to local prominence of the implant. In cases where the metal implants are asymptomatic, the justification for removal is related to complications that have been associated with retention of metal implants. The problems include local osteopenia and bone resorption, metal toxicity, and implant fatigue with fracture. The removal of an implant is not a benign procedure and the potential for complications is real. Cost can be considerable since the procedure often requires an anesthetic and use of an operating room.

Richards et al cited a 3% complication rate with routine hardware removal.⁴ His reported complications included refracture, neurovascular injury, and wound infection. When we retrospectively reviewed the cost of implant removals, the mean hospital charge for implant removal in 87 cases was \$4,410.

In general, we now prefer the plastic fasteners to metal screws. They are particularly suitable for cases where plates are not used since the need to reoperate on the patient can be avoided. Poly-L-lactate screws and pins are flush with the surface of bone when correctly inserted and do not cause the same local irritation as the corresponding metal screws. The implants will absorb 1 to 2 years after insertion.

PLLA screws and rods are now our implant choice. We believe this technology will continue to evolve and that plastic screws will become the commonplace in the treatment of a great many fractures in the future.

ACKNOWLEDGEMENT: The authors wish to thank James Miller for introducing us to this material.

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POPULATION ATTITUDES TOWARD ONCOLOGY CLINICAL TRIALS

Joseph Valentino, MD; Michael A. Andrykowski, PhD; Teresa A. Wood, PhD

Objective: We examined the attitudes of the Kentucky adult population toward experimental oncology treatment and randomized clinical oncology trials. **Design:** We conducted a health survey of 654 noninstitutionalized adults randomly selected from Kentucky households. We posed to them a series of questions evaluating demographics, general health, and personality characteristics. We asked specific questions to characterize the subjects' experiences with cancer, their desires for autonomy in medical treatment, their health-related behaviors, and their preconceived opinions about specific cancer screening examinations. We then asked the subjects about their willingness to undergo experimental treatment and their willingness to participate in a randomized clinical oncology trial within the framework of a defined, specific oncology scenario. **Results:** Of our subjects, 73% were willing to consider an experimental form of therapy of indeterminate benefit; however, only 39% were willing to consider a randomized clinical trial of two therapies, given the same oncology scenario. The influences of demographic factors, general health, personality factors, personal experience with cancer, and desire for autonomy in health care were found to be of minimal importance in predicting a willingness to participate. **Conclusions:** A strong negative bias toward randomized clinical trials appears to exist within this population. Continued public education regarding the value of clinical trials to the individual, as well as their selfless benefit to humanity, is clearly needed.

rates and their analyses of the factors resulting in non-entry.¹⁻⁷

Many of the concerns of physicians and patients about clinical trials have common themes, including ethical concerns, loss of physician input into treatment decisions, and loss of patient autonomy in treatment decisions. These concerns are heightened when the trial is a randomized controlled trial: as many as 70% of physicians and 90% of patients express concerns about such trials.^{8,9} Hypothetical situations posed in surveys of oncology patients elucidate many aspects of clinical trials that affect their biases toward participation. The negative impact of assignment to treatment in a trial (ie, that neither the patient nor the physician would decide upon the therapy used) was an often repeated, strong influence against participation.⁸⁻¹¹

Preconceived biases regarding human trials have been poorly studied in the general population. These biases will have an impact on the patient related factors that affect accrual rates. Many physicians perceive a deterioration of the physician-patient relationship when they treat a patient as part of a clinical trial.^{8,12} If our society at large has a bias against clinical trials and human experimentation, physicians who are uncomfortable enrolling patients in randomized studies have validation for that discomfort. They may be uncomfortable because they share that societal bias, or they may be ethically troubled at the thought of imposing clinical trials on the unwilling population.

The general population's attitude toward clinical trials is largely unstudied. Most studies analyze ill patients, leaving unstudied the attitudes of patients' significant others and family members. These individuals frequently have a great impact upon a patient's decision to

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Although clinical trials form the foundation for advances in cancer treatment, the accrual of patients to these trials has been problematic within the United States. At our institution, approximately one quarter of the oncology patients approached for enrollment are accrued to trials. Multiple factors influence these accrual rates. Many authors have reported their accrual

enroll in clinical trial. In a large portion of our referral population, the immediate and extended families travel great distances to meet with the physicians at the time of treatment decisions. The influence of these people on such decisions in our experience is significant and may help to explain hidden factors that contribute to difficulties with accrual in our region.

We wished to study the Kentucky population's attitude toward participation in clinical cancer trials. We wished to examine our population for factors that may correlate with a person's willingness to participate in experimental therapy. The analysis of oncology patients at one hospital by McCusker et al showed sociodemographic differences between patients treated on protocols and those eligible but not treated on protocols.⁴ Depression and self-perceptions of poor physical health are common characteristics among patients with cancer. Personal biases are built in large part from a collection of experiences. Personal experiences with cancer and the observation of others with cancer may also contribute to biases about clinical trials. Study of these factors and their impact upon general population attitudes toward clinical trials was warranted.

We sought correlations within our population between biases about trials and belief in established medical advances in early detection. We postulate that rejection of these advances may indicate a general negative bias against medical scientific endeavors, or a nihilistic bias regarding the usefulness of any cancer intervention. A patient with a strong desire for autonomy in treatment decisions may be less willing to accept randomization than a more passive patient.

By understanding socioeconomic data and related attitudes, we may be able to better understand the people that are unwilling to participate in clinical trials as well as the other individuals that may influence them. We could then target specific populations with an educational effort. Better knowledge of the unwilling population will help to evolve an appropriate, successful, educational approach to encourage accrual to clinical trials.

MATERIALS AND METHODS

Procedure

The protocol for this survey used computer-assisted telephone interviewing. Quality-control procedures included telephone monitoring, supervisor follow-up verification, postinterview coding and editing, and consistency check analysis of all final data files. Households were selected at random by using random-digit dialing that gives every residential telephone line in Kentucky an equal probability of being called. The first respondent over 18 years of age in the household was the only person in that household questioned. A total of 654 calls to the 1179 eligible households (55.4%) resulted in complete interviews. Demographic characteristics of the 654 survey respondents are shown in Table 1.

Survey Questions

The survey from which the current data were obtained included 188 questions and required approximately 20 minutes to complete. In the final interview, questions were clustered to examine access to the health care system, mental health, perceptions of general physical health, experience with cancer among friends and relatives, belief in the efficacy of cancer detection methods, and attitudes toward treatment decision-making and toward clinical trials. Other clusters of questions included in the overall survey examined topics such as practice of health behaviors, awareness of hereditary cancer risk, and health care utilization. Demographic information regarding respondents' race, age, gender, and education was also obtained.

Attitude Toward Treatment Decision-Making. Preference for autonomy in oncology treatment decision making was assessed by the question, "Suppose your doctor discovered that you had cancer. The doctor knows of five different ways in which your cancer could be treated. Each treatment has different side effects and chances of curing your cancer. Some of the treatments are newer and have unknown side effects. Please tell me which statement most closely

Table 1. Demographic Data of the Study Population

Category	N (%)	Valid %
Gender		
Men	271 (41.4)	41.4
Women	383 (58.6)	58.6
Community		
Rural	213 (32.5)	32.8
Small Town	307 (46.9)	47.3
City	130 (19.9)	20.0
DK	4 (00.6)	Missing
Age		
>60	153 (23.5)	23.5
40--60	263 (41.9)	42.1
18--39	237 (34.6)	34.4
Marital Status		
Married	402 (61.5)	61.5
Separated	18 (02.8)	02.8
Divorced	89 (13.6)	13.6
Widowed	69 (10.6)	10.6
Never Married	73 (11.2)	11.2
Cohabiting	3 (00.5)	00.5
Race		
Caucasian	615 (94.0)	94.3
Minority	37 (06.0)	05.7
Education		
< High School	113 (17.3)	17.3
≥ High School	541 (82.7)	82.6
DK or Ref	1 (00.2)	Missing
Income		
< \$10,000	97 (14.8)	17.9
\$10,000--\$25,000	154 (23.6)	28.5
\$25,000--\$50,000	137 (20.9)	25.3
> \$50,000	152 (28.4)	28.4
DK or Ref	113 (17.3)	Missing
Family or Close Friend Ever Have Diagnosis of Cancer?		
Yes	477 (72.9)	73.0
No	176 (26.9)	27.0

matches what you would prefer to do. Would you: (1) Want your doctor to fully disclose all the possible treatments with you, explaining his/her preferences and reservations about each treatment, so the two of you can *decide together* which treatment to use in your case? (2) Want your doctor to tell you only about the treatment she/he feels is best in your case and *follow the doctor's recommendation*? (3) Want your doctor to fully discuss all the possible treatments with you, explaining his/her preference and reservations about each treatment but let *you decide* which treatment you want the doctor to use in your case?" Respondents then indicated which of three options they would prefer.

Attitude Toward Experimental Treatment and Randomized Treatment Trials. Our dependent variables of interest were assessed by two questions. Willingness to participate in experimental treatment was assessed by the question, "Suppose you had a type of cancer which could only be cured in one out of four of the people who have it using the best treatment currently available. How willing do you think you would be to try a new experimental treatment with an unknown chance of curing your cancer; in other words, it may be better or worse than the treatments currently used?" Response options were "very willing," "somewhat willing," "not very willing," and "not at all willing."

Willingness to participate in a randomized treatment trial was assessed by the question, "In order to discover which one of two treatments is best for a particular type of cancer, doctors conduct experiments using patients. The kind of treatment a patient receives is randomly assigned on the basis of a coin toss. Again, suppose that you had a type of cancer which could only be cured in one out of four of the people who have it using the best known treatment. How willing would you be to let the doctor flip a coin to decide which type of experimental treatment you were to receive? Remember, the doctor doesn't know which type of treatment works best. That is what he or she is trying to find out." Response options again were "very willing," "somewhat willing," "not very willing," and "not at all willing."

Statistical Analyses

Given a sample size of 654 respondents, the margin of error for the survey is less than 4% at the 95% confidence level. Before analyses were carried out, the educational level of the respondents was dichotomized as completion of high school or less vs some education beyond high school. Cancer experience in first degree relationships was also dichotomized as no experience with cancer in a first degree relationship ($n = 409$) vs cancer in one or more first-degree relationships ($n = 245$). Cancer experience in second-degree relationships was similarly di-

Table 2. Population's Willingness to Participate in Experimental and Randomized Treatment Trial

	Not At All Willing N (%)	Not Very Willing N (%)	Somewhat Willing N (%)	Very Willing N (%)	Total N (%)	DK or Ref
Willingness to Participate in Experimental Treatment	81 (13.2)	87 (14.2)	325 (52.9)	121 (19.7)	654 (100.0)	40
Willingness to Participate in Randomized Treatment Trial	224 (36.4)	149 (24.2)	188 (30.6)	54 (8.8)	654 (100)	39

(%) represents valid percentage excluding subjects who did not know or did not respond.

chotomized as none ($n = 308$) vs cancer in one or more second-degree relationships ($n = 346$). Race was dichotomized as either Caucasian ($n = 615$) or minority ($n = 37$).

Kruskal Wallis analysis of ranks, corrected for ties, was used to analyze relationships between the responses to our questions regarding willingness to participate in experimental treatment and randomized treatment trials and the categorical demographic, treatment access, cancer experience variables, and attitude towards cancer treatment. Pearson's Product-Moment Correlation was used to analyze the relationship between respondents' willingness to participate in an experimental treatment or willingness to participate in a randomized treatment trial and respondents' ages and indices of mental health, perceived physical health, and belief in cancer detection. Logistic regression was used to identify multivariate predictors of willingness to participate in experimental treatment and a randomized treatment trial. An alpha level of 0.05 was used as the criterion for statistical significance.

RESULTS

Willingness to Participate in Experimental Treatment or a Randomized Treatment Trial

Nearly 70% of respondents were either "very willing" (121 of 654; 19%) or "somewhat willing" (325 of 654; 50%) to participate in an experimental treatment. (See Table 2). A significant positive relationship between belief in the efficacy of cancer detection methods and willing-

ness to participate in experimental treatment was found ($r = .12$; $p < .01$). All other correlations between willingness to participate in experimental treatment were not significant.

The majority of respondents (57%) were either "not very willing" (149 of 654; 23%) or "not at all willing" (224 of 654; 34%) to participate in a randomized treatment trial. (Table 2). Not having a personal physician was significantly associated with greater willingness to participate in a randomized treatment trial ($\chi^2 (1) = 6.26$; $p < .02$), as was experience with cancer in friends and relatives ($\chi^2 (1) = 13.35$; $p < .001$). No other correlations were significant.

Kruskal Wallis analysis indicated no significant relationship between preference for autonomy in oncology treatment decision-making and willingness to participate in either an experimental treatment ($\chi^2 (2) = 2.96$; n.s.) or a randomized treatment trial ($\chi^2 (2) = 1.01$; n.s.). However, a significant relationship was evident between willingness to participate in experimental treatment and willingness to participate in a randomized treatment trial (Spearman $r = .39$; $p < .0001$). (Table 3).

Multivariate Prediction of Willingness to Participate in Experimental Treatment or a Randomized Treatment Trial

A pair of identical logistic regression analyses was performed to identify multivariate predictors of willingness to participate in experimental treatment or a randomized treatment trial. Predictor variables in both analyses included dichotomous variables representing gender, race (Caucasian vs minority), education (\leq high school education vs $>$ high school education),

Table 3. Population's Willingness to Participate in Randomized Treatment Trials (Stratified by Willingness to Participate in Experimental Treatment)

	Very Willing N (%)	Somewhat Willing N (%)	Not Very Willing N (%)	Not At All Willing N (%)	Totals N (%)
Very Willing	36 (31.0)	34 (29.0)	17 (15.0)	30 (26.0)	117 (20.0)
Somewhat Willing	14 (4.0)	129 (41.0)	89 (28.0)	86 (27.0)	318 (53.0)
Not Very Willing	3 (3.0)	13 (15.0)	32 (37.0)	38 (44.0)	86 (14.0)
Not At All Willing	0 (0.0)	6 (8.0)	8 (10.0)	63 (82.0)	77 (13.0)
Totals	53	182	146	217	598

possession of private health insurance (yes vs no) or a personal physician (yes vs no), and experience of cancer in a first-degree (none vs one or more relationships) or a second-degree relationship (none vs one or more). Additional predictor variables including age (< 45 years vs \geq 45 years) and scores for belief in efficacy of cancer detection, mental health, and perceptions of physical health were created by dichotomizing at the sample median. Two dichotomous dependent variables were created by combining "very willing" and "somewhat willing" responses and "not very willing" and "not willing at all" responses for both willingness to participate in experimental treatment and willingness to participate in a randomized treatment trial. The predictive model based upon this set of 11 variables was not significant with respect to willingness to participate in experimental treatment (model χ^2 (11) = 9.76; n.s.). However the predictive model was significant with regard to willingness to participate in a randomized treatment trial (χ^2 (11) = 19.73; $p < .05$). Three variables emerged as significant multivariate predictors of *unwillingness* to participate in a randomized treatment trial. Specifically, respondents without a personal physician (Odds Ratio = .58; $p < .05$), with experience with cancer in at least one second-degree relationship (Odds Ratio = .62; $p < .01$), and with greater belief in the efficacy of cancer detection methods (Odds Ratio = .69; $p < .05$) were about one-half to one-third *less likely* to indicate unwillingness to participate in a randomized treatment trial. In other words, these three variables were associated with greater willingness to participate in a randomized treatment trial.

DISCUSSION

The most glaring finding from the analysis of this study is the simple decrement of people willing to participate in clinical trials when the concept of randomization is added. Willingness dropped from 71% to 39%, despite the fact that all other aspects of the oncology scenario were identical. As one might predict, willingness to participate in experimental treatment correlated well with willingness to participate in a randomized treatment trial. However the correlation was only 0.39. The finding that our Kentucky population has significant reservations about participation in the 'gold standard' experimental trial was not surprising, because it falls into alignment with observations of previous studies.⁹

We found most of the factors we examined had no significant effect on one's willingness to participate in a clinical trial. We examined the influence of sociodemographic variables on the willingness of our Kentucky population to participate in experimental treatment with or without randomization, and found none. Some reports point to differences in the perceptions of cancer by various ethnic groups.¹⁴ Our data support no attitude differences attributable to race, gender, health insurance, or household income among our respondents. Differences in education have also been implicated in patients' behavior regarding cancer treatment.¹⁵ We discovered no such relationship between education and willingness to participate in experimental or randomized treatment trials. These findings argue that an individual's decision to participate in a trial is independent of most socioeconomic factors.

We searched extensively for other variables in our survey that might correlate with the willingness to participate in either Phase II or Phase III types of experimental design. We examined the relationships between perceived health and mental health as defined by a collective score of item responses described in the material and methods section. Neither variable correlated with willingness to participate.

We did find some correlation between the attitudes and biases that were examined. We expected that an individual's desire to autonomously select cancer treatment would negatively impact upon willingness to participate in trials, due to lack of control in these scenarios. Surprisingly, our measure of autonomy in the decision-making processes regarding their cancer treatment had no influence. A person who believed that cancer detection was useful and helpful was more likely to be willing to participate in randomized treatment trials. The correlation between having a personal physician and willingness to participate in a randomized treatment trial was small but significant. Personal experience with cancer was examined because it may form part of a person's bias for or against experimental cancer treatment. Those without experience were less willing to participate in randomized treatment trials. The odds ratio was small but nonetheless significant. Each of these factors relates to the individual's experience with health care or cancer. In each case, the group with less experience or less belief in traditional treatment was less willing to participate in this simulated randomized treatment trial. Of course, a substantial amount of further investigation would be necessary to clarify this inference.

Our goal was to define willingness to participate in clinical studies in our Kentucky population. However, we have the obvious limitations of a fictional scenario with little personal investment on the part of the respondents. Of course, the respondents might react quite differently if they or a loved one were actually faced with these decisions. We chose a fixed scenario with defined life expectancies. Perhaps the answers would have been differ-

ent if the survival rates had been varied, or if the scenario had been altered in other subtle ways. Breast cancer patients were dramatically influenced by changes in these factors, as well as by other quality-of-life factors.⁹ The phrasing of the scenario itself was an oversimplification of a complex situation. A telephone survey does require one to be brief; however, a better description of the study arms and their presumed efficacy might improve respondents' expression of willingness to participate in clinical trials. Further exploration of these and other factors that generated the responses would be helpful.

Although we did, indeed, find some variables with statistically significant effects on willingness to participate, the effect was small. These differences do not explain most of the variance in the data, leading us to conclude that other important factors were not examined, or that these decisions are simply independent.

Unlike most of the reported literature that studied the attitudes of patients, we studied the attitudes of the general population. Twenty-seven percent of our respondents had no personal experience in observing the effects of cancer or cancer treatment. This population, whose attitude regarding clinical trial treatment was previously unstudied, has a statistically significant negative bias against this treatment. A reasonable supposition is that these people are more likely to have misunderstandings about cancer treatment as well as experimental cancer treatment. Often, the decisions of an individual patient are made after discussion with family members and significant others. These people may influence a decision about participation in a clinical trial for a friend or relative. Perhaps more positive information about clinical trials would sway these people to support trials.

Correction of the negative attitude toward randomization within the general population is imperative if we are to continue to improve the rates of accrual to these important trials. As Cassileth eloquently points out, experimental treatment is easy to recommend for the "anonymous others"; however, such a decision in a per-

sonal situation probably generates an entirely different response.¹⁶ Although this phenomenon is not unexpected, we as scientists and clinicians must educate the population about the benefits to the individual of participation in oncology clinical trials to overcome it. The mass media tend to present the results of clinical trials either as new breakthroughs or in relation to the impact of the results on pharmaceutical stocks. Issues of cost, benefits to the general population, and ethics are rarely topics of concern, and discussions of study design and randomization issues are even more unusual. We have demonstrated that attitudes toward experimental treatment are independent of the usual demographic variables. Any media campaign or public relations effort needs to address the entire population within the state of Kentucky, because we cannot demonstrate a particular segment with stronger negative feelings.

In 1988 the National Cancer Institute (NCI) began a vigorous and ongoing campaign to encourage enrollment in clinical trials through national and local media, publications, video tapes, and a telephone-based information service. This effort of the NCI led to an increase in referrals to NCI centers.¹⁷ Unfortunately, the number of patients involved in national trials still remains at a disappointing 2.5% of those whose cancer is newly diagnosed.¹⁸ If most patients with the new diagnosis of cancer fully understood the uncertainties involved in treating cancer and actually sought out clinical trials, accrual rates would be greatly improved.

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Carolyn D. Burns, MD

ART VS SCIENCE

*...it is not an easy task
to achieve that necessary
balance of pragmatism
and compassion.*

There was a recent editorial that I read in my Missouri University Alumni Association Magazine written by an emeritus pediatric professor at the University Hospital. This editorial was reprinted posthumously. I was struck by several comments.

This piece primarily addressed the difficulty for families at the loss of a loved one and very often the great quantity of adversity that some people have in their lives. I was touched when the author spoke about . . . listening to the pain without the encumbrances of false assurance . . . and our duty as physicians to share in our patient's suffering thus engendering hope and strength.

There are obviously those subspecialties that deal with these types of situations more than others. I cannot begin to fathom the amount of personal fortitude and resilience that those physicians must have. All physicians will from time to time meet this type of situation, and it certainly causes one to reflect on how people seem to maneuver through life in the face of hardships. I, myself, have recently had several patients contact me directly concerning their pathology reports. There have been times I have been nearly moved to tears

listening to a patient's account of their illness and then attempting to help them comprehend the nature of that diagnosis or disease. I have found myself feeling somewhat of a failure when I realize that there is nothing left in my armamentarium that will completely relieve their pain.

I read this article and after some reflection realized that it is acceptable not to have any more answers. It is acceptable not to know or understand any better than our patients and it is acceptable to admit when we have gone beyond our own ability and technology. It is often necessary to quietly listen and support our patients and their loved ones. Yet it is not an easy task to achieve that necessary balance of pragmatism and compassion. I would imagine that many of our patients and their families would appreciate knowing that we as physicians suffer along with them and very often are angry at the hand they have been dealt.

Once again, these types of situations emphasize that the art of medicine, although more difficult, can actually be important and more soothing than the science.

Carolyn D. Burns, MD

The 5 Minute Child Health Advisor

M. William Schwartz, MD, Editor
Williams & Wilkins, Baltimore

This 337-page book, including an excellent index, is a nice paperback complement to the child rearing home. Packed with page after page of dictionary-like information presented uniformly in segments, the subjects covered seem to reach most of the common situations that parents confront.

Some parts discuss a symptom, with the "basics" being an overall description, signs and symptoms, causes, and scope. Then the diagnosis is briefly touched, with standard tests and thinking patterns discussed. Treatments are listed, but no medication dosages are given. Finally activity, diet, common questions, and prevention are minimally noted. Specific diseases or problems are somewhat more technically and thoroughly presented, but the basic outline is the same. The

benefit and clarity of succinct information balance any fault with brevity and omission.

That the audience of readers could include not only lay parents, but also those of us wearing both the parental and medical caps makes this book handy and very useful. After looking at the 250 health problems covered, the reader should feel more comfortable with the burden of caring for children.

Stephen Z. Smith, MD
Book Review Author

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Jan Crase

HOW ABOUT A BREAK?

Don't you deserve to get away from your work and relax for a couple of days? Let's look ahead to April for just a moment.

The income taxes will be paid by April 15th, the frustration of working so many months each year to pay those taxes will be at its peak, and spring fever will be in full swing. As you are pondering your pockets being turned wrong side out and thinking "How can we be more frugal," or better yet, "I wish those who govern this country would be more frugal,"—how about a mini vacation in one of Kentucky's vacationlands that just happens to be one of the cheapest places in the entire country to live.

Each year millions of visitors come to the Lake Cumberland area to enjoy the rugged beauty of the lake's 63,000 surface acres and 1,255 miles of wooded shoreline. How about taking a break to accompany your spouse, maybe bring the whole family, to Beautiful Lake Cumberland and enjoy yourself during the **Kentucky Medical Association Alliance Annual Meeting.**

If you fish, there are seven varieties of popular fish beneath the lake's surface. Maybe you would like catching a 58 lb rockfish, a 22 lb walleye or a


catfish weighing an amazing 208 lbs, and that's no fish story! Other varieties include crappie, bream, trout, and five species of bass.

Are you a Civil War buff? Visit Mill Springs Civil War Battlefield and the smallest National Cemetery in the country. Do you golf? With five challenging and beautiful golf courses, Somerset and Burnside are home to some of Kentucky's finest vacation golf. Add to all this the parks and hiking trails, historic tours (including the beautifully preserved grist mill and waterwheel at Mill Springs), family fun, shopping and dining, plus the nearby attractions of Cumberland Falls, Renfro Valley, Big South Fork (to be the Yellowstone of the East when complete), and you have a full package. This is where Jim and I have chosen to call home and this is where the KMAA convention will be held in April. Get a taste of country living as we go to Renfro Valley for dinner and a country hoe down. Transportation will be provided to and from all events of the convention.

Get out your country duds, get a smile on your face, and a relaxed attitude, then tell your spouse to scoot over that you are coming with him or her to the convention. Have some fun,

good fellowship, and learn more about the Alliance. The more you learn about us the better you will like us.

Jan Crase
KMAA President

Please turn the page for a complete meeting agenda and registration form. 

WHAT: 1999 Kentucky Medical Association Alliance Convention

WHEN: April 19, 20, 21, 1999 (Monday, Tuesday, Wednesday)

WHERE: Somerset, Kentucky
Hampton Inn, with some meetings at the Rural Development Center

SCHEDULE: (Transportation will be provided to and from all activities and events)

Sunday, April 18, 1999 — on your own — golfing, fun, fellowship

6:00 PM-9:00 PM Hospitality Suite Open for the early birds (complimentary supper)

Monday, April 19, 1999

All meetings at Hotel with lunch at Riverstone Gallery

7:00 AM-9:00 AM Hotel Hospitality Suite open (complimentary breakfast)

9:00 AM-12:00 NOON Registration

8:00 AM-11:30 AM Committee Meetings — Hotel Meeting room

12:00 NOON-1:30 PM Lunch at Riverstone Gallery/Greetings from AMAA & SMAA and surprise guest speaker.

2:00 PM-3:00 PM Pre-convention board meeting

Denim and Diamonds Evening

5:00 PM-6:30 PM Reception overlooking lake — home of Dr & Mrs El Nagggar

7:00 PM-9:00 PM Dinner & Country Entertainment — Renfro Valley

Tuesday, April 20, 1999

All meetings to be held at The Center for Rural Development, 2292 S Hwy 27, Somerset

7:00 AM-9:00 AM Hospitality Suite open (complimentary breakfast)

7:30 PM-9:00 AM Delegate registration — Center for Rural Development

7:30 AM-8:00 AM Set up displays — The Center

8:30 AM-12:00 PM House of Delegates meeting

12:00 PM-2:00 PM Luncheon honoring past presidents/Recognize members-at-large/KY Heritage Project video/Speaker Ruth Ryan

Basket auction to benefit McDowell House — Representative Danny Ford

Auctioneer, Minority Leader of the House

2:30 PM-3:30 PM Transition meeting for Officers & Chairs

5:30 PM-7:00 PM Reception honoring President-Elect Carolyn Daley and 1999-2000 Board of Directors at home of Dr & Mrs Kavanagh

7:30 PM Dinner — Eagles Nest Country Club/Greetings from KMA

Presentation of AMA Foundation checks to UL & UK, awards

Installation of officers — Colleen Adam, President AMAA

Carolyn Daley's inaugural speech

1999-2000 KMAA officers are:

<i>President</i>	Carolyn Daley, Hazard
<i>President Elect</i>	Dr Nancy Swikert, Northern Kentucky
<i>Recording Secretary</i>	Vicky Borders, Ashland
<i>Treasurer</i>	Kay Florence, Busy
<i>Vice President Membership</i>	Sandi Frost, Somerset
<i>Vice President AMA Foundation</i>	Diane Cox, Louisville
<i>Vice President Legislation</i>	Mimi Davis, Owensboro
<i>Vice President Health Promotion</i>	Karen Shank, Lexington

Wednesday, April 21, 1999

7:00 AM-8:30 AM Hospitality Suite open (Complimentary breakfast)

8:30 AM Post Convention Board Meeting

12:00 noon Hotel check-out

Alliance spouses are welcome to all activities and events.

Mail registration form to Gwyn Parson, 117 Rebel Dr, Somerset, KY 42501

Registration for KMAA Convention, Somerset, KY — April 19, 20, 21, 1999

Name _____ Phone _____

Address: Street _____ City _____ Zip _____

Arrival date: _____ Departure date: _____

Registration fee: (none for spouses)	\$10.00 _____
Monday lunch — Riverstone Gallery	\$12.00 _____
Monday night — Renfro Valley dinner, entertainment, bus	\$20.00 _____
Tuesday lunch — "Center"	\$20.00 _____
Tuesday night dinner — Country Club	\$25.00 _____
Total	\$87.00 _____

Please check activities attending and send check with registration

For hotel reservations call the Hampton Inn, 4141 S Hwy 27, Somerset, 606.676.8855 and let them know you are with the KMAA to get special rates of \$55/night single or \$65/night double occupancy + tax.

If you have any questions regarding the convention please contact: Joyce Clark at 606.274.4707 or Sandi Frost at 606.678.5493.

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NEWSMAKERS

Ernest D. Fletcher, MD, Lexington, was sworn in as a new member of Congress in the US House of Representatives in early January. Dr Fletcher represents the 6th Congressional District.

Kentucky State Representative **Bob M. DeWeese, MD**, Louisville, was appointed Vice Chair of two important House Committees, Health & Welfare and Appropriations & Revenue, at the legislature's Organizational Session.

Polly A. Coombs, MD, Louisville, was one of only two medical professionals chosen from Kentucky to participate in the Education for Physicians on End-of-Life Care (EPEC) program from the AMA's Institute of Ethics.

The EPEC project will deal with essential clinical competencies including palliative care, ethical decision-making, symptom management, communication skills, and psychosocial issues. More information about the EPEC Project is available at <http://www.amaassn.org/ethic/epec>.

John R. Dimar II, MD, Louisville, received the 1998 Hibbs Award for best basic scientific research on the spine. The award was presented to Dr Dimar by the Scoliosis Research Society at their annual meeting.

Dr Dimar is an orthopaedic surgeon and associate professor in the Department of Orthopaedic Surgery at the University of Louisville. His research inves-

tigated the effect of spinal canal narrowing and timing of decompression on neurological recovery after spinal cord injury in rats.

The paper was co-authored by **Steven D. Glassman, MD**; **George H. Raque, Jr, MD**; **Yi Ping Shang, MD**, and **Christopher B. Shields, MD**.

James M. Kleinert, MD, and **Heidi Bas, MD**, won the American Society of Surgery of the Hand Emmanuel Kaplan Award at the society's annual meeting held in Minneapolis. The award honored the best anatomy paper of the year.

Dr Kleinert of Kleinert, Kutz and Associates Hand Care Center, PLLC is associate clinical professor of orthopaedic surgery at U of L School of Medicine.

Dr Bas is a research fellow with the U of L School of Medicine's Division of Plastic and Reconstructive Surgery.

The paper, entitled "Anatomic Variations in Sensory Innervation of the Hand and Digits," was to be submitted for publication in the *Journal of Hand Surgery*.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

BOYLE

Gary M Bunch MD S
130 Daniel Drive
Danville 40423-0129
1988, U of Kentucky

Teresa A Johnson MD IM
765 Ridgeway Rd
Stanford 40484
1987, American U of the Caribbean

CAMPBELL

Darla Cahill MD PD
2062 Bridgette Ln
Hebron 41048-9101
1992, U of Kentucky
Michael K Davenport MD S
3220 Huntersridge Ln
Taylor Mill 41015-4332
1991, U of Louisville

CHRISTIAN

Daniel A Lopez MD AN
106 Thornton Ct Apt I
Hopkinsville 42240
1990, Creighton U, Nebraska

CLARK

Michael K Kuduk MD PD
375 Bob White Ln
Winchester 40391
1989, UMDNJ, New Jersey
Sidney D Trogon MD S
1111 McCann Dr
Winchester 40391
1987, E Carolina U, Greenville

HENDERSON

Xiaoli Chen MD PTH
2012 Brookstone Dr
Henderson 42420
1987, Beijing, Med U China

HOPKINS

Paul J Arnold DO EM
2209 S Main St
Madisonville 42431
1976, Kirksville Col, Missouri
Michael G Black MD EM
200 Clinic Dr
Madisonville 42431
1993, U of Michigan

James W Bonds Jr MD	<i>S</i>	Steven W Etoch MD	<i>S</i>	Michael R O Recto MD	<i>PD</i>
331 Fox Chase Cir		2107 Indian Chute		9306 Springbrooke Cir	
Madisonville 42431		Louisville 40207-1188		Louisville 40241-3004	
1975, U of Tennessee		1991, U of Arkansas		1987, U of the Philippines	
John Broadbent MD	<i>C</i>	Darla K Granger MD	<i>S</i>	Greg W Rennirt MD	<i>ORS</i>
200 Clinic Dr		726 Fairhill Dr		10518 Fairview Ave	
Madisonville 42431		Louisville 40207-1304		Louisville 40299-3723	
1990, U of Louisville		1988, U of Minnesota, Minneapolis		1992, U of Louisville	
James K Cooper II MD	<i>AN</i>	Ann-Regran Grider MD	<i>OBG</i>	Milagros T Rivera MD	<i>FP</i>
200 Clinic Dr		914 Bridgecreek Rd		7302 Springdale Rd	
Madisonville 42431		Louisville 40245-5173		Louisville 40241	
1991, W Va School of		1994, U of Louisville		1993, Dacca Med Col Bangladesh	
Osteopathic Med		Christopher L Hill MD	<i>IM</i>	Martine Robards PhD	<i>PSY</i>
Bryant D Draper MD	<i>EM</i>	1919 State St Ste 240		801 Barrett Ave Ste 103	
3055 Deep Creek Dr		New Albany 47150		Louisville 40204	
Madisonville 42431		1994, Kirksville Col, Missouri		1973, Basic Med Florida State U	
1995, Spartan Health Sciences,		Ross T Hockenbury MD	<i>ORS</i>	Mark A Severtson MD	<i>OTO</i>
West Indies		12404 Mistletoe Rd		6420 Dutchman's Parkway Ste 380	
Gerald A Dysert MD	<i>OBG</i>	Anchorage 40223		Louisville 40205	
205 Abbott Lane		1985, U of Louisville		1992, Columbia U New York	
Madisonville 42431		Matthew T Jung MD	<i>S</i>	Catherine L Sewell MD	<i>PTH</i>
1973, Ohio State		4003 Kresge Way Ste 100		1918 Lowell Ave	
Mary A Haering DO	<i>P</i>	Louisville 40207		Louisville 40205	
200 Clinic Dr		1992, U of Missouri, Columbia		1986, U of Louisville	
Hopkinsville 42431		Marianne E Majkowski DO	<i>N</i>	Marvin L Swanson MD	<i>OBG</i>
1991, Michigan State, East Lansing		250 E Liberty Ste 202		601 S Floyd St Ste 300	
Gregory J Stark MD	<i>PD</i>	Louisville 40202		Louisville 40202	
500 Clinic Dr		1992, Michigan State		1971, U of Iowa	
Hopkinsville 42240		Walter G McFarland MD	<i>N</i>	Darrin J Violi DMD	<i>DENT</i>
1991, U of Tennessee		14015 Harbour Pl		576 Hawthorne Ave	
Alan J Thorner MD	<i>EM</i>	Prospect 40059		Shelbyville 40065	
200 Clinic Dr		1993, U of Kentucky		1993, U of Louisville	
Madisonville 42431		Ronald L Morton MD	<i>PD</i>	Laura P White MD	<i>PD</i>
1979, Temple U, Pennsylvania		233 E Gray St Ste 201		5129 Dixie Hwy Ste 201	
		Louisville 40202		Louisville 40216	
		1988, U of Illinois, Chicago		1991, U of Louisville	
HARDIN		Jeffrey T Omer MD	<i>IM</i>	KENTON	
Syed R P Quadri MD	<i>IM</i>	250 East Liberty St Ste 410		Brett V Kettelhut MD	<i>A</i>
570 Charlemagne Blvd		Louisville 40202		810 Windgate Court	
Elizabethtown 42701		1995, U of Louisville		Villa Hills 41017	
1984, M R Med Col, India		Thomas C Passo MD	<i>C</i>	1982, U of Nebraska	
		225 Abraham Flexner Way Ste 305		KNOX	
JEFFERSON		Louisville 40202		Azhar Aslam MD	<i>IM</i>
David A Dues MD	<i>IM</i>	1972, Indiana U		200 Chestnut St Apt 5	
2400 Mellwood Ave Apt 503		Barry R Pecha MD	<i>U</i>	Corbin 40701	
Louisville 40206		234 E Gray St Ste 3		1989, Dow Med Col, Pakistan	
1993, U of Louisville		Louisville 40202			
		1992, U of Tennessee			

LINCOLN

Narendra N James MD
PO Box 388
Stanford 40484
1989, Universidad de
Montemorelos, Mexico

FP

James W Martin MD FP
Brook Massey MD FP
Tamberly McCoy MD FP
James E Wheeler II MD FP
Bret Wittmer MD FP

JEFFERSON

McCRACKEN

David G Stricklin MD
225 Medical Center Dr
Paducah 42002
1983, U of Missouri, Columbia

IM

Giovannie M C Eugenio MD FP
Glen A Franklin MD S
Maria C M Ignacio MD AN
Muhammad I Masroor MD IM
Prasun C Ray MD IM
Paul C Lin MD OBG
Jason E Mattingly EM
Siobhan M O'Connor MD OBG

MONTGOMERY

John E Merryman MD
250 Foxglove Dr Ste 1
Mount Sterling 40353
1990, U of Cincinnati

S

PERRY

Enrico Ascani III MD
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Hazard 41701
1994, Louisiana State U,
New Orleans

OBG

WARREN

Kela L Fee MD
1805 Scottsville Rd
Bowling Green 42104
1993, U of Louisville
Charles T Slack MD
131 Lee Ann Ct
Bowling Green 42103-9739
1990, U of Texas, Dallas

OBG

PS

WHITLEY

Harold W Reedy Jr MD
1015 Gunners Trce
Corbin 40701
1993, U of Kentucky

R

IN TRAINING

HOPKINS

Kristy L Crandell MD
Stephanie Dunagan MD

FP

FP

Family Practice, which honored her with their Citizens Award for "Doctor of the Year" in 1974; a tireless advocate for full modern health care for the people of northeastern Kentucky; and a well-known civic leader in Rowan County. She graduated from the University of Louisville School of Medicine in 1946 and was an active member of KMA.

Wynant Dean, MD
Sanibel, FL
1914-1999

Wynant Dean, MD, a retired ophthalmologist, died January 23, 1999. A 1940 graduate of Yale University School of Medicine, Dr Dean was a life member of KMA.

OBITUARIES

Frederick C. Reiss, MD
Louisville
1925-1998

Frederick C. Reiss, MD, a retired general surgeon, died December 5, 1998. Dr Reiss was a 1952 graduate of the University of Louisville School of Medicine and a life member of KMA.

C. Louise Caudill, MD
Morehead
1912-1998

C. Louise Caudill, MD, who delivered some 8,000 babies, was instrumental in establishing Morehead's St. Claire Medical Center, and practiced family medicine in Rowan County and surrounding areas for more than 50 years, died December 31, 1998. Dr Caudill was a past president of the Northeast Kentucky Hospital Foundation; a charter member of the Academy of

KMA 1999 Practice Management Series

The Kentucky Medical Association, in conjunction with Kentucky Medical Insurance Company and Conomikes Associates, presents the following series of statewide practice management workshops. These workshops are designed to provide Kentucky's physicians and their staffs with opportunities to improve interoffice systems so the focus remains the patient - not paperwork.

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Risk Mgmt., 4:00 pm – 6:00 pm

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The sequel to a Coding Basics course offered in February - attend and learn proven **Advanced Coding** techniques. Learn to implement **Corporate Compliance** plans that reduce the likelihood of fraud and abuse in your practice.

When and Where:

May 11, Louisville
May 12, Lexington
May 13, Covington

Advanced, 9:30 am – 4:30 pm
Compliance, 6:00 pm – 9:00 pm

Managed Care and Corporate Compliance

Learn the basics of the key issues surrounding **Managed Care** from the physicians' viewpoint and how to reorganize your practice. **Corporate Compliance** is a repeat of the courses provided in May.

When and Where:

June 1, Somerset
June 2, Owensboro
June 3, Hopkinsville

Managed Care, 9:30 am – 4:30 pm
Compliance, 6:00 pm – 9:00 pm

Workshop Pricing

	<u>Member</u>	<u>Non-member</u>
Audit-proof and Managed Care	\$195 ea.	\$225 ea.
Compliance	\$79 ea.	\$99 ea.
Both for Discount Fee	\$245	\$300
KMIC Risk Mgmt.	<u>Physicians</u> \$50	

Registration Form

Please indicate workshop(s) you want to attend:

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Workshop: _____ Location: _____

Name: _____ Are you a KMA Member?: _____

Practice: _____ Address: _____

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Please mail Registration Form with your check for registration fees to KMA, 4965 US Hwy. 42, Suite 2000, Louisville, KY 40222, attn: Seminars or fax your registration with credit card number and expiration date and signature to (502) 426-6877. You will receive confirmation of your registration with directions to exact locations. If you have questions, please call Marty White at (502) 426-6200.

KMA Young Physicians Seek E-mail Addresses

Chaired by **Judy M. Linger, MD**, Georgetown, KMA's Young Physicians Steering Committee recently met to discuss special concerns of this group, comprised of physicians 40 years or younger and/or those in their first 5 years of practice. Plans for the AMA YPS Interim Meeting and KMA Annual Meeting were reviewed.

The committee agreed that increasing awareness among young physicians of the work of organized medicine is an important task. In order to facilitate communication among this group, the committee recommends that members send e-mail addresses to KMA via *member@kyma.org*.

Search the National Guideline Clearinghouse (NGC)

The National Guideline Clearinghouse (NGC) is a unique Internet-based tool accessible at <http://www.guideline.gov>. The NGC was developed by AHCPR, in partnership with the American Medical Association and the American Association of Health Plans (AAHP), to be a resource for physicians, nurses, and other health care professionals.

As of December 1998, the NGC contained 200 evidence-based clinical practice guidelines submitted by over 50 health care organizations and other entities. All submissions are abstracted

into a standardized format that enables users to compare clinical practice guideline recommendations more quickly than ever before. After the first 5 years of operation, this repository is expected to contain 3,500 clinical practice guidelines. NGC's electronic database will be updated continually, to reflect the most recent clinical practice guidelines.

You can search the NGC database three different ways: by disease/condition; by treatment/intervention; or by the name of the submitting organization. You also will be able to conduct simple and detailed searches. In addition, NGC allows you to create tabular comparisons of guideline abstracts and provides syntheses of guidelines that cover similar topics, noting areas of agreement and disagreement.

If you have questions or comments about the NGC or have questions about how to submit guidelines to NGC, contact Ms Jean Slutsky, NGC Project Officer, at the Agency for Health Care Policy and Research by calling 301.594.4042 or by e-mail at: jslutsky@ahcpr.gov.

K-Chip Program Begins Enrolling Patients

A toll-free number is available for patients to sign up for the Kentucky Children's Health Insurance Program (K-CHIP). Families between 100% and 200% of poverty may qualify for K-CHIP, which is expected to be implemented July 1, 1999. Maxi-

mum income limits for K-CHIP are:

- \$21,700 for a family of 2
- 27,300 for a family of 3
- 32,900 for a family of 4

An estimated 55,000 Kentucky children are uninsured and eligible for K-CHIP. Another 23,000 children are also eligible for Medicaid under expansion authorized by the 1998 Kentucky General Assembly. K-CHIP provides preventative services such as dental and vision care, as well as basic health care services. Families will be required to pay premiums set according to income level and co-pays when receiving health care services. Kentucky is currently determining how to include state employee children who were omitted from the original state plan. Patients may call the Cabinet for Health Services toll free 1-800/635.2570 Monday through Friday between 8:00 AM and 4:30 PM EST.

KMA to Distribute New Legal Handbook to Membership

The KMA will be providing a new product to active members entitled *Legal Handbook for Kentucky Physicians*. The book contains over 140 pages of material discussing various topics of interest to physicians, as well as sample documents physicians can use in their practices. The book will be distributed to members *free of charge* upon KMA receiving dues for the 1999 year. Look for it in your mail.

Medicaid Managed Care Update Available

The KMA's Medicaid Managed Care Committee met recently and received updates on the various Medicaid Partnerships around the state. If you would like a copy of KMA's latest report on the Medicaid Partnerships, contact the KMA legal department at phelps@kyma.org.

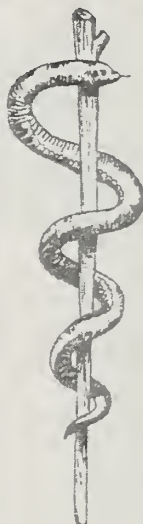
Federal Government Issues "Fraud Alert" Aimed at Physicians

The federal government occasionally issues guidance that addresses problem areas within Federal health care programs which may constitute fraud and abuse. These guidance statements are known as "fraud alerts." The latest fraud alert concerns physician certifications for durable medical equipment and home health services. If you would like a copy of this fraud alert, contact the KMA legal department, or log on to the government's home page at <http://www.dhhs.gov/progorg/oig/frdalrt/index.htm>.

Clarification on the New Prescription Blank Requirements

Under a law passed during the 1998 General Assembly, written prescriptions for controlled substances must be on security blanks that meet specific guidelines set out by regulation.

Prescriptions provided orally to a pharmacist, however, are not required to be on a security prescription blank for Schedules III, IV and V drugs. If you have questions about this, contact the Drug Control Branch of the Department for Public Health at 502/564.7985.



Impaired Physicians Program

502.425.7761

WHEN SMOKERS QUIT

Within 20 minutes of smoking that last cigarette, the body begins a series of changes that continues for years.

20 MINUTES

- Blood pressure drops to normal
- Pulse rate drops to normal
- Body temperature of hands and feet increases to normal

8 HOURS

- Carbon monoxide level in blood drops to normal
- Oxygen level in blood increases to normal

24 HOURS

- Chance of heart attack decreases

48 HOURS

- Nerve endings start regrowing
- Ability to smell and taste is enhanced

2 WEEKS to 3 MONTHS

- Circulation improves
- Walking becomes easier
- Lung function increases up to 30 percent

1 to 9 MONTHS

- Coughing, sinus congestion, fatigue, shortness of breath decrease
- Cilia regrow in lungs, increasing ability to handle mucus, clean the lungs, reduce infection
- Body's overall energy increases

1 YEAR

- Excess risk of coronary heart disease is half that of a smoker

5 YEARS

- Lung cancer death rate for average former smoker (one pack a day) decreases by almost half
- Stroke risk is reduced to that of a nonsmoker 5-15 years after quitting
- Risk of cancer of the mouth, throat and esophagus is half that of a smoker's

10 YEARS

- Lung cancer death rate similar to that of nonsmokers
- Precancerous cells are replaced
- Risk of cancer of the mouth, throat, esophagus, bladder, kidney and pancreas decreases

15 YEARS

- Risk of coronary heart disease is that of a non-smoker



Source: American Cancer Society, Centers for Disease Control and Prevention



HEALTH CARE ALTERNATIVES

KMA Annual Meeting
Sept 27 - 30
Hyatt Regency/Lexington Center
Lexington, Kentucky

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All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

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The Rural Kentucky Medical Scholarship Fund is accepting applications from residents of Kentucky, who have been accepted to one of the state's accredited medical schools. The Fund offers a \$12,000 loan for each year of medical school to a qualified recipient who is willing to practice and reside in a rural county in Kentucky for one year for each loan received. Repayment options include low interest rates for recipients practicing in rural areas and loan forgiveness for those practicing in areas of the state with critical needs. Counties considered to be rural and critical are determined by the RKMSF annually. The Fund is the oldest and most successful of its kind in the nation. The Rural Kentucky Medical Scholarship Fund has loaned approximately \$4 million to over 600 medical students. The deadline date for filing an application is *April 1, 1999*. Those interested in applying for a scholarship loan should contact the RKMSF Office at the Kentucky Medical Association Headquarters, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222, or call 502-426-6200.

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Manuscripts — Articles will be accepted for consideration with the understanding that they are original and are contributed solely to this *Journal*. The transmittal letter should designate one author as correspondent and include the author's address and telephone number. Receipt of manuscripts will be acknowledged and unused manuscripts returned. All material is reviewed by the Board of Editors and publication of any article is not to be deemed an endorsement of the views expressed therein.

Preparation — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.

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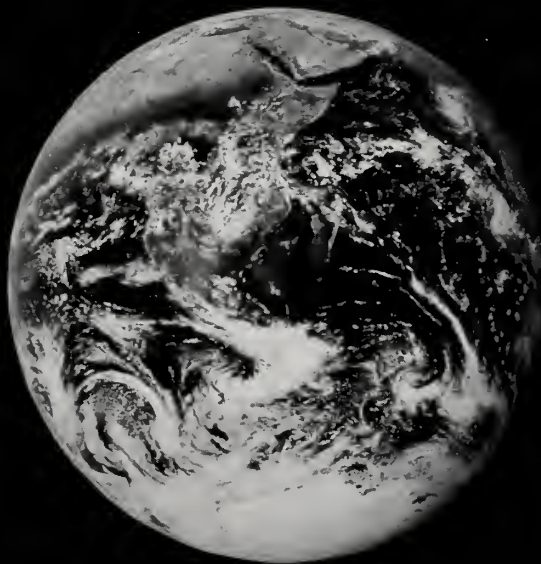
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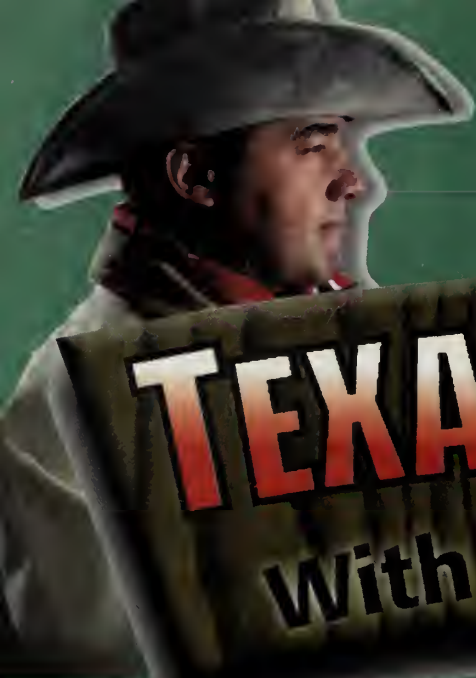
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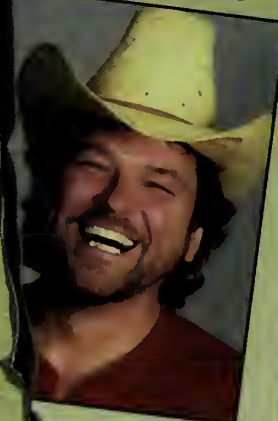
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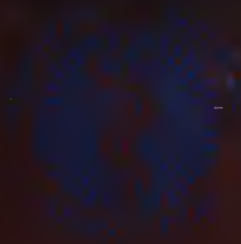
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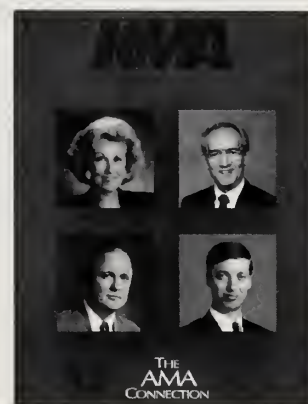
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COVER:

To inform you, our members, on what is taking place on your behalf at the AMA, the Journal is publishing interviews about the involvement, thoughts, and observations of the four leaders pictured on this month's cover. This month we profile Robert R. Goodin, MD, a member of the AMA Council on Medical Education. Subsequent issues will profile Ardis D. Hoven, MD; William B. Monnig, MD; and Bruce A. Scott, MD.

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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Periodical postage paid at Louisville, KY and additional offices. Yearly subscription rates: \$35 domestic; \$45 foreign. Single issues \$4 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222. Telephone 502/426-6200 Fax 502/426-6877 Email member@kyma.org

Listed in *Index Medicus*. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

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Printed by the Ovid Bell Press, Inc, Fulton, Missouri 65251.

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Kentucky Medical Association

Website: www.kyma.org

MEDICAID MANAGED CARE AND ITS EFFECT UPON HEALTH DEPARTMENTS AND THE UNINSURED



In March 4, J. Michael Moore, MD, President of the Fayette County Medical Society, made an excellent presentation to the KMA Committee on State Legislative Activities regarding the impact of Medicaid managed care upon the Fayette County Health Department. The Fayette County Health Department has provided care to over 15,000 uninsured patients, many of whom Dr Moore labeled "the working poor." To resolve the problem brought on by managed care and the reassignment of patients, it has been estimated that each Fayette County primary care physician could be assigned 76 of the Health Department's "uninsured." According to Dr Moore, even if this could be accomplished, private practicing physicians would not have access or support from ancillary products and services such as drugs, lab, and x-ray. Due to the development of the Bluegrass Regional Medicaid managed care program, health departments within that region are now required to compete with private primary care physicians for patients. The loss of reassigned Medicaid patients to private practitioners, who previously received their care at health departments, created a drain on the Fayette County Health Department's budget and its ability to provide care to the uninsured indigent. The State Legislative Committee held considerable discussion on the matter, and also noted that Jefferson County is facing the same problem.

As noted by State Legislative Chair Wally O. Montgomery, MD, the KMA is faced with what one could label "the horns of dilemma." KMA's ability to invoke itself into this discussion is considerably hampered by long-standing House of Delegate positions. The

House of Delegates has clearly stated and periodically reaffirmed its opposition to the delivery of primary care from the health department setting. The disparity of reimbursement between primary physicians and health departments for the same service has been a source of irritation for years, and has led to a great deal of enmity between primary care physicians and local health departments. Continuity of care, particularly for evening or weekend services, has been a major point of contention. Historically, health departments received reimbursement at a rate of 5-6 times what primary care physicians receive for the identical medical service.

In addition to KMA's long-standing position on the delivery of primary care from the health department setting, the Association's position on Medicaid managed care further compounds KMA's ability to respond. The Board of Trustees and House of Delegates is on record as being extremely cautious of managed care in Medicaid. From the outset, KMA questioned the ability of managed care to restrict access or services to Medicaid patients under existing federal laws, which clearly permit Medicaid patients to ignore traditional managed care restrictions and practices. In my own region, Medicaid patients who find the wait in physician offices too long, head for the hospital emergency room for routine treatment. The hospital and ER physician, required by federal law to see the patient, are then denied payment for the service. END RESULT—The provider's claim is denied; the insurer saves money; and the provider is prohibited from billing the patient.

In 1997, the Secretary of CHR confirmed to the Board of Trustees that Medicaid was being administered for less than 3% on the dollar. Members of the Board noted that managed care would be far more costly, and could significantly reduce patient expenditures and create pockets of uninsured. On more than one occasion, the KMA raised questions about the future of health departments. When a former Secretary of CHR was specifically queried by the KMA Board of Trustees as to the future of health departments in the vast Medicaid managed care scheme, his comment was essentially, "they'll have to fend for themselves."

In early 1997, KMA officers and staff met with the Governor on two occasions, urging delay in the implementation of Medicaid managed care until Regions 3 and 5 proved to be successful. The Governor and Secretary informed KMA officials that Medicaid managed care would be implemented. During the 1998 Kentucky General Assembly, KMA sought to place statutory constraint upon further implementation of Medicaid managed care in Kentucky. Regions 3 and 5 joined with the KHA and the Administration to foil KMA's efforts. Members of the General Assembly also had ample opportunities to address the "shortfall," but chose to spend the budget surplus on other items.

The Board of Trustees' greatest fears have now been realized—even at a time when the Cabinet for Health Services is plunging pell mell ahead in Region 8, a region which is home to 25% of Kentucky's poor and indigent. **The system as originally designed by former Governor Brereton Jones and his Cabinet Secretary, Mastin Childers, is working as intended—it saves money—but at the expense of the uninsured indigent.** We find it amusing that major proponents of Medicaid managed care back in 1994-95, including several members of the General Assembly and the print media, now lead the "hue and cry" against a system they championed on behalf of Governor Jones over KMA's objections.

The Kentucky Medical Association remains concerned about the implementation of Medicaid managed care in Kentucky. Imposition of managed care in Medicaid, as has occurred in the private sector, always comes at the expense of the poor and indigent. **As managed care grows, the uninsured population grows.** Providers, particularly those with an indigent and poor patient base, have had their fees dramatically reduced and are being forced to operate in a bureaucratic managed care system. They are no longer permitted to transfer portions of the cost of treating the uninsured to insurers, and access to care for the uninsured is becoming severely restricted and marginalized. The Association recognized, from the outset, Medicaid managed care's potential impact upon health departments and the continuing ability of private practitioners to treat the uninsured indigent. On more than one occasion we cautioned Governor Jones and his administration of the pitfalls of Medicaid managed care. **Our warnings were ignored then and are being ignored now** as the Secretary of the Cabinet for Health Services presses for the institution of Medicaid managed care in Kentucky's poorest region. Once again, KMA urges delay in implementation of Medicaid managed care in other regions in Kentucky until the General Assembly can be assured that managed care in regions 3 & 5 can be implemented without threatening patient care.

The KMA urges Governor Patton, Secretary Morse, and members of the Kentucky General Assembly to review the issue of delivering primary care from health departments, and other methods of addressing Kentucky's uninsured. The KMA is prepared to enter into dialogue with the Administration and the interim legislative committees to address the immediate concerns of the poor and uninsured and their ability to access necessary primary medical care.

Donald R. Stephens, MD
KMA President

MONITORING Medicine

NEWS FOR KENTUCKY PHYSICIANS

Board of Medical Licensure Adopts Policy Statement Relating to Complementary and Alternative Therapies

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DEFINITIONS:

Complementary and Alternative Therapies:

Is defined as "... a broad domain of healing resources that health systems, modalities, practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period."

The various offerings of alternative medicine fall into one of three categories:

1. Invalidated: defined as interventions that are "invalidated" because they have neither a proven nor any scientific basis for any health benefit. Invalidated remedies include any therapy that:
 - a. Is implausible on *a priori* grounds (because its implied mechanisms or putative effects contradict well established laws, principles, or empirical findings in physics, chemistry or biology).
 - b. Lacks a scientifically acceptable rationale of its own.
 - c. Has insufficient supporting evidence derived from adequately controlled outcome research.
 - d. Has failed in well-controlled studies done by impartial evaluations and has been unable to rule out competing explanations for why it might seem to work in uncontrolled settings.
2. Nonvalidated (plausible but not yet proven): Refers to treatments and interventions that may have a basis in scientific theory for use in medical care but that are otherwise unproven, innovative and/or experimental. This includes drugs, medical and surgical interventions, and regimens that are offered and accepted by a patient on the basis of potential benefit, and that have neither been accepted nor discredited by the expert clinical community.

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Nonvalidated therapies are distinct from, on the one hand, customary and accepted treatments, and, on the other, invalidated remedies.

3. Validated (proven to be efficacious).

Therapies generally associated with these definitions:

1. Homeopathy
2. Chiropractic
3. Acupuncture
4. Additional therapies: Aroma therapy, Art therapy, Biofeedback, Body work/manual therapy, Botanicals/herbs, Environmental, Hypnosis, Light therapy, Magnetic stimulation, Mind/body medicine, Music therapy, Nutrition, Traditional Chinese medicine, Yoga, Supplements, Chelation, Massages, Reflexotherapy, etc.

The Kentucky Board of Medical Licensure is aware that an increasing and significant number of citizens of the Commonwealth of Kentucky are seeking complementary and alternative therapies in their health care. The Board recognizes that physicians are increasingly incorporating complementary and alternative therapies in their care of patients. The Board recognizes that innovative practices that could benefit

patients and improve care should be given reasonable and responsible degrees of latitude. Abusive criticism of alternative practitioners and threats to their licensure solely because they offer their patients an integrated practice will not be tolerated.

On the other hand, the Kentucky Board of Medical Licensure is aware of the Attorney General's findings that consumer fraud does occur in the practice of medicine. If consumer protection means anything, it should protect people weakened by illness from the dangers attendant to unsound—invalidated health practices. The Board is concerned with whether it is proper for physicians and providers to offer, agree to manage jointly or to accede to patient demands for alternative therapies that may not be particularly harmful, but for which little or no proof of potential benefit exist. The Board feels that physicians and providers should *never* accede to *invalidated* treatments. The Board does believe that physicians *may* incorporate *non-validated* treatments if research results are very promising, if the physician believes that a particular patient may benefit, if the risk of harm is very low, *and* if

the physician adheres to the conventions that govern the doctrine of informed consent for nonvalidated treatment. The Board will continue to protect the citizens of the Commonwealth of Kentucky by:

1. Ensuring that Licensees employ and document the medical model in their overall evaluation and treatment of the patient (ie, history, physical, diagnosis, plan of treatment, and periodic assessment and follow up).
2. Ensuring that the Licensee has the requisite training and skills to perform the particular procedure.
3. Ensuring that Licensees honestly and fully explain the various procedures available for treatment of the particular condition, to include the risk and benefits of such treatment option or procedure, and
4. Carefully scrutinizing any treatment which results in harm to the patient.

The Board believes this policy finds support in traditional ethical principles and is not outweighed by the competing principle of patient autonomy.

Adopted September 17, 1998.

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ROBERT R. GOODIN, MD AMA COUNCIL ON MEDICAL EDUCATION

Four KMA members serve in elected leadership roles in the American Medical Association. For a relatively small delegation of five Delegates and five Alternate Delegates, that is a significant accomplishment.

To inform you, our members, on what is taking place on your behalf at the AMA, the Journal is publishing interviews about the involvement, thoughts, and observations of these four leaders—"The AMA Connection."

This month we profile Robert R. Goodin, MD, a member of the AMA Council on Medical Education. Subsequent issues will profile Ardis D. Hoven, MD, Member, Council on Medical Services; William B. Monnig, MD, Secretary, Governing Council, Organized Medical Staff Section; and Bruce A. Scott, MD, Member, Board of Trustees, Young Physicians Designated Position.

JKMA: What are the mission/main areas of responsibility of the AMA Council on Medical Education?

Dr Goodin: The mission of the AMA Council is to serve as the body that develops educational policy for the AMA and, therefore, for physicians around the country. This relates to education at the medical school, residency and fellowship training levels, as well as continuing medical education, which makes up about 30 or more years of our education.

JKMA: What current issues are you dealing with?

Dr Goodin: There are probably three major issues. To me, the num-

ber one issue would be the physician work force. As many are aware, a consensus building process was undertaken about two years ago, which was highly endorsed by six different organizations that have vested interest in the education of medical students, residents, and practicing physicians. There are enough students and resident physicians currently in the pipeline. That number does not need to increase, because there is major potential for having excess physicians within the near future. The Council has policy, but doesn't have the ability to enforce it because of anti-trust restrictions. This requires, most importantly, legislation on the Washington end.

A real problem arises in that we have the same number of medical student graduates in this country now as we have had for almost 20 years. However, the number of first year residency positions has grown enormously, and now there are 40% more first year residency physicians than there are US graduates. What that means is that we import physicians. It does not mean we do not want to continue to train international medical graduates. It does mean, however, that they and we have major problems if our physician excess is going to be enormous. None of this is conducive to providing good quality care that is cost effective.

Our current focus is on putting together a major hearing at the

AMA Leadership Conference scheduled for the end of March, in another attempt to build a consensus on "where are we and what are our next steps." Major efforts are planned for the legislative end in Washington, to basically inject logic into the funding of graduate medical education. For now, Medicare would continue, but an all payer system would be established. As a result of his first bill not getting out of committee, Senator Daniel Patrick Moynihan has reintroduced a bill to establish an all payer system. The numbers in that bill establish a goal of 110% of US graduates for the first year residency spots, rather than 140%. That makes sense.

A second topic of great interest and concern was discussed at our most recent meeting in Chicago. The Federation of State Medical Licensure Boards has come down with a recommendation that major changes be made in licensure requirements. These are, of course, all state level decisions since each state has its own licensure board. The Federation wants to see all states require three full years of residency for licensure. That would greatly affect us in Kentucky, as we currently require only one year for US graduates. They are advocating that moonlighting not be allowed. Also, that residents simply be given permits and that those permits be renewed every year, and only after the program directors give them a report. What is really frightening is

the recommendation that medical students, who are not even physicians, come under the jurisdiction of the licensure board, along with a requirement that medical schools report to their board any disciplinary action. The Federation is very vague about specifics. They talk in terms that could be construed that if students are reprimanded or disciplined because they are late getting their charts or dictations done, it would be a reportable incident. Some 25 different organizations including medical schools, residency programs, and state medical associations were represented at that meeting. Our Council is very involved in this.

And finally, our theme for the next year, as is generally true across the AMA, is a concept of getting all physicians to "recommit" themselves to professionalism. This should begin in medical school the day of the "White Coat Ceremony." Students should be introduced to the concept that on that day they enter a profession, and it is incumbent upon all of us physicians that they understand what we define as a profession. We want to be true professionals in this world of medicine—not tradesmen, not craftsmen, not technologists, not providers, nor any such concept. All across the AMA, we realize this theme must be pervasive and reemphasized at every level of medical education.

I'm very excited about promoting professionalism with the students. I feel it can be accomplished without overcrowding the curriculum. Of great concern to the Council on Medical Education is the fact that medical school curricula and residency curricula are absolutely packed. Yet, we're being charged to introduce more—to teach students about managed care issues, and how to become more

efficient without jeopardizing quality. The concepts of emphasizing ethics, professionalism, and the other big one of emphasizing a commitment to lifelong education are areas where we could do better. These are a part of the whole concept of professionalism, and the Council on Medical Education should play an integral role.

JKMA: *How do these issues and efforts affect or have impact on members, the practice of medicine, and the overall profession?*



Dr Goodin: Concerning members, certainly every physician, in their most sincere moments, would say that the part of their profession of which they are most proud is their extensive level of education. Total commitment to education, being educated, and staying educated throughout our careers separates our profession from other professions. The success of our Council goals can have a major effect on future generations of physicians.

In daily practice, an area of major involvement for me on the Council is an assignment to the Accreditation Council for Continuing Medical Education (ACCME), and that fits. I'm one of few Council members who do daily medical

practice, and the Council needs the input of practicing physicians to make knowledgeable decisions. These decisions affect the practice of medicine because more and more medical boards, state licensure boards, hospitals, and specialty societies are requiring ongoing medical education. My goal is to make relevant continuing medical education more available and less expensive.

The two real roots of our profession are education and ethics. No other profession has been granted the incredible privilege to have intimate interaction with patients and to care for medical needs of people. As with all worthwhile privileges, this comes with a price—it requires the ultimate in total professional dedication, honesty, integrity, and knowing what the heck we're doing. And that means education.

JKMA: *What is your major goal as a member of the Council on Medical Education?*

Dr Goodin: My major goal from the beginning has been to add a voice for the private practice sector. Our Council is made up of 12 members. Eleven are physicians elected by the House of Delegates, including one resident physician, and one medical student is appointed by the Student Section. Currently there are two full time practice physicians on the Council; often there is only one. Experience dictates that there should be at least one, because the others—academicians, those in administrative medicine, medical school deans—need input about private practice and how it can be done better. Not only are they interested in how we should be teaching at the undergraduate and graduate education levels to equip physicians to deal with managed care and other areas of today's practice, but also in postgraduate continuing

physician education. Faculty have to practice to help pay for medical education. Honestly, 50% of the average medical school budget is made up by faculty practice income. We need to know this in the private sector. It is important that we not feel they are taking advantage by competing with us. This is just the way it is funded. So, they need to be educated on how to practice efficiently, and a physician with my years of practice experience can provide needed input. To serve on the Accreditation Council for Continuing Medical Education is certainly an opportunity for me to add a voice. Those members who do not practice medicine many times do not understand why I, or a rural Kentucky physician for instance, pursue continuing medical education. Frequent questions are: What am I looking for? what should it cost? what are the subjects?

JKMA: *How are issues this Council deals with and their priorities determined?*

Dr Goodin: In a very good way. The House of Delegates elects the Council. The House of Delegates forwards resolutions and recommendations to the Board of Trustees and they in turn assign them to the appropriate group. If they involve education, they are assigned to us, one of six major councils that would deal with the issues. Currently we report back through the Board, but that is being changed to report directly to the House of Delegates. This is the way it should be, because our recommendations will get a full hearing and exposure at the following semi-annual AMA meeting.

Within the Council, we have a chair and a chair elect. The chair technically assigns duties within the Council and along with staff prepares our meeting agenda. Selec-

tions are made according to ones interests. In other words, if we were dealing with a series on the Ecology of Medicine, we would look at the environment of various sectors. The last two I chaired involved the environment of undergraduate and graduate medical education. I, along with a task force of three other members of the Council, considered the emotional and physical environment of medical school support services, and the same for residency. Basically, this is how we determine the priorities and ultimately develop AMA policy.

JKMA: *What is the greatest strength of the Council on Medical Education?*

Dr Goodin: Just that—Medical Education. I can speak personally, having been a full time educator earlier in my career, and now teaching students and residents every day on a volunteer basis. My involvement on the Council has provided a unique opportunity to view medical education from many perspectives.

Another great strength of the Council is that it is open to an election. Members have to be elected by the House of Delegates. In this case, that is much better than being appointed. The House of Delegates is made up of physicians like myself and others from all over the country. We really do know what is going on in the trenches. As a result, we have the insight to select Council members capable of representing physicians with the diversity that is needed.

JKMA: *What area of this Council needs more effort?*

Dr Goodin: A higher profile. Reimbursements, insurance issues, and other practice matters are extremely important to physicians for their livelihood and keeping their offices open. That's a natural. As a result, we often tend at the AMA to be over

focused on the hot items of the day and place too little focus on what our real core values were and are. We simply tend to get our priorities out of kilter. I understand this has been a chronic situation for a long time—and probably natural. Our Council is working hard on this area. We've had strong leadership on the Council in recent years and strong members with the ability to be creative on how we become involved with issues. There were often educational components to many issues in which we were not involved in the past. That is improving.

JKMA: *AMA membership in Kentucky continues to be stable, although AMA membership has been declining over the past few years, nationally. Why, in your opinion, should physicians support the AMA?*

Dr Goodin: The stability in Kentucky has been maintained by KMA through both staff and physician leadership. During my almost 30 year involvement, I've witnessed a tremendous caliber of leadership translated into a highly effective KMA, which afforded Kentucky physicians a clear view of what organized medicine can accomplish for us. Kentucky is small enough that the president and staff can visit many parts of the state and reach physicians receptive to hearing what AMA accomplishes. Receptive to the concept that, right or wrong, we would have absolutely nothing in this profession if we didn't have the AMA as our umbrella organization. Nationwide, some states, especially the larger ones, became very divisive in their liability insurance programs, how they required membership here, or didn't there. As a result, it's become easy for physicians to find an excuse to not join AMA. To me, this is the real problem, and I do feel it is being addressed.

JKMA: *What do you see as the greatest impediment to AMA membership?*

Dr Goodin: The decline in recent years is not because AMA has been less effective, but because reimbursements have fallen. Because of this greater crunch on physicians' income, they look at placing that extra \$400 on a lower priority. I think I understand that, but AMA has made changes recently, and there is not just an emphasis on the old reasons for being actively involved; there are new concepts. My own personal view is that the AMA already does ten times more than what we pay. It's important that physicians know that only 40% of the AMA budget comes from membership dues. This says that AMA is doing a lot of other things, through their publications, *JAMA*, and other areas, to make our dues a lot less.

JKMA: *What is your view on the recent change in leadership of JAMA?*

Dr Goodin: First of all, let me say that Dr George Lundberg clearly elevated the status of the *Journal of the American Medical Association*, and much of the credit goes to him. We need to remember, though, that he had a solid editorial support staff. It is my understanding that this was not an isolated event, that there were other developing areas of disagreement in recent years. The timing was unfortunate because it gained a lot of press from both sides. Moving the article up for publication was probably inappropriate for a physician organization that's certainly not trying to be partisan. On the other hand, the timing of his dismissal might have been arranged a little differently. This was a very unfortunate incident.

JKMA: *The AMA House of Delegates made some significant changes in the structure and governance of the AMA.*

Describe some of these changes and how they will affect the membership and the operation of the AMA.

Dr Goodin: In the past five years there has been a huge initiative on the part of AMA and its House of Delegates to be more responsive to our members. It's easy to become an inefficient bureaucratic system in an effort to generate dollars to offset member dues increases. But if our focus is there, we tend to forget that we're really a physician professional organization. Recent changes prompted by the Sunbeam ordeal have brought the AMA back into focus. This situation led to a terrific opportunity to, number one, establish a new look for AMA's strategic plan, which is now in place; and number two, a couple of House of Delegate committees and their consultants researched in great depth ways to become more efficient, more streamlined, and I think they have accomplished that. There has been a refocus on the core values of AMA.

We must remember that as large as AMA is, it cannot represent all physicians. That is not possible, what with academic physicians, administrative physicians, practicing physicians, specialties, subspecialties, etc. There are some very effective specialty and state medical societies, yet we can't achieve what we need legislatively without the AMA. We are attempting to streamline the process so we don't duplicate each other's efforts and at the same time reduce our organized medicine dues by at least a third.

This also led to major changes in the Board of Trustees. One area that affects the Council of Medical Education and other councils is the realization that our members may be better versed and better able to give testimony on some issues

throughout the country or in various House or Senate committee meetings than members of the Board of Trustees on some issues. This lightens the workload for the Board of Trustees job. Very few people can either afford, choose, or want to make a commitment to give up 100 to 120 days a year of their life to serve on the AMA Board of Trustees. The Board is reorganizing to become a more efficient machine.

JKMA: *What is the most critical issue facing the AMA? What should be done or is being done about it?*

Dr Goodin: The decline in membership. Less than 40% of practicing physicians belong to AMA, and probably as low as 32%. In the past, membership development was more of a "get out the message" only. With the recent restructuring, a Board of Trustees member has been assigned to chair membership and to develop a networking system, including nonmembers, to determine why, for example, academicians, women, younger physicians, do not join at the same percentage. We need to get the message out on what the AMA really accomplishes. Honorable physicians will respond to that.

JKMA: *In what area does the AMA need to expend more effort?*

Dr Goodin: Restructuring and changing governance structure within the AMA itself. AMA became a system all to its own. Many times it left out the input of people from whom it needed input. Another major effort I hope to see continued is "let's have for example specialty societies do what specialty societies do best." In most cases that would be continuing education, and even major input to us about educational standards. For example when a new subspecialty

board comes into play, as recently happened in cardiology. Legislatively they do a good job, but they cannot do it without help from the AMA. Likewise, state, county and larger city medical societies do things that clearly AMA can't do, and shouldn't be doing. We should not be duplicating activities. Obviously, this involves a lot of diverse groups; it is a difficult process. But we need to sit down and talk with each other, because if we don't make them more efficient, then they all get worse.

JKMA: *What changes or new directions would you like to see occur for the AMA?*

Dr Goodin: This is dreaming of course, and I can't say I have a solution. But in the process of taking another look at our goals in education, our Council realized education wasn't the only crucial element—it was just a part of it. What kept surfacing was declining professionalism. In many cases we're not conducting ourselves as professionals, and we're certainly being treated as nonprofessionals by many parties, such as third party payers, business entities, and sometimes by legislators. My dream is to find the key to beginning the development of professionalism on day one of medical school, propagating that and making it grow as the student becomes a resident, and all the way through our practice careers. To avoid changes and cynical attitudes that seem to develop inevitably when people are worked too hard and paid less than they feel they should be. To find a way to have a higher percentage of physicians totally committed to the kind of professionalism that does not compromise what's best for the patient—regardless of ability to pay, where they come from, how much their insurance company pays, or what

plan they have. The greatest risk to the profession may be allowing ourselves to continually be "dumbed down." I know so many Kentucky physicians, and the vast majority are truly committed to professionalism. But, it doesn't take many that are not to spoil the whole basket.



Professionalism must begin at the student level and continually role modeled through medical school and residency. We can't just tell them, they must see us acting as professionals. Physicians who exemplify professionalism must be willing to educate students and residents.

AMA has bought into the concept of professionalism being a focus of every issue. No matter what council, where it takes place, what board member is speaking to what group—we must focus on professionalism. The greatest beneficiary of this could be the patient, who has a whole lot more at stake than we physicians do.

JKMA: *Patient Protection was the primary legislative goal of AMA in 1998. While Congress failed to enact patient protection reforms in 1998, what is the outlook in 1999 and what other AMA legislative goals are we seeking in Washington?*

Dr Goodin: This is a situation where often we are painted as a profession that is always on the Republican side. Let's face it, this is an area where we must agree completely that Patient Protection is critical. Now how we reach this, whether through a Republican bill or a Democratic bill, we should not care. We must select one we think is sufficient to provide the patient protection we need, and support it. I understand this is back to priority one with this year's legislature. With 32 states now having passed bills with varying degrees of patient protection involved, the support will have grown enough within the House and Senate, that maybe something can be accomplished there. I think the outlook is good for 1999.

Another big legislative goal in Washington is, as mentioned earlier, Senator Moynihan's reintroduction of his bill to address funding of graduate medical education. The concept being a stable source of funding, and not just Medicare, which is subject to legislative increase or decrease. Senator Moynihan feels that other parties should be involved in financing medical education. For example, HMOs and insurance companies are also beneficiaries of well-educated physicians and, of course, the public is as well. Medical education is a public good that needs to be supported. What they and we would agree completely is that it should be an "all payer" fund administered by an independent group, partially public and partially government. The point being, if independent, they could assess the needs on an ongoing basis and make non-political decisions.

The implementation of Medicare reforms is another concern. The ultimate problem with many reforms that sound great in the bill

itself, is that when the guidelines are written, it doesn't come out quite like we thought.

Another area where I hope we see legislation on both a national and state level is to increase even further the protection of our patients from intrusion by third parties into the actual practice of medicine. I understand the business side, the importance of managed care and containing cost. But when it compromises quality of patient care, we must be allowed to be the judge. We don't want too much government intervention, but this is one area where we need control on those parties in order to redefine who carries the license to practice medicine.

JKMA: *What do you see as the greatest strength of the AMA?*

Dr Goodin: The overwhelming number one strength is that, as we now exist, AMA is the only umbrella organization representing physicians. AMA does not accomplish all the things we would like, but on the other hand, it has the enormous challenge of representing all physicians. Like everything else, the way to make it better and to address areas of disagreement is to be involved. It is extremely difficult for 33% of physicians to support the entire profession. In addition to being the only umbrella organization, it is a democratic process. Sometimes we think too much so in the sense we spend too much time working on issues. There's no question that AMA is the representative body for all physicians when it comes to legislation, setting standards on education and ethics, etc, and I do feel it should continue to represent us. Unless one sees all that takes place behind the scenes and away from the press and the media, then it's difficult to

assess the extent of AMA's accomplishments, especially in light of the membership base.

JKMA: *One final question. You've held numerous leadership positions at the state level with KMA, and for several years have been in that circle of top leaders at the national level with AMA. How does KMA measure up from the standpoint of benefits to members, its leadership, etc?*

Dr Goodin: When we visit other states or even other countries and say we're from Kentucky, occasionally there's a certain stereotype—I think they're looking for the hole in our sock. But I can tell you that at the AMA that is not true. KMA is very, very highly regarded at the AMA. The reason for this is truly a tribute to Bob Cox and now Bill Applegate and KMA staff. They're a huge reason for our success, for our good membership. We are consistently well represented on issues. It is interesting that Kentucky basically represents one percent of the physicians in the country and, therefore, one percent of the House of Delegates. The demographics are that even though we're two percent population wise, we have only one percent of US physicians. Kentucky does very, very well as a percentage of membership of practicing physicians in the state compared to most states. Our success ultimately is attributable to the combination of staff and KMA physician leadership representing all parts of the state, almost all specialties, and certainly all points of view. Our physicians out in the state see their preferences and wishes and needs translated into action. Through everything from seminars to staff or physician leadership meetings throughout the state, KMA is doing what a good organization should do.

Drs Ardis Hoven, Bill Monnig, Bruce Scott, and I are fortunate to have attained current leadership levels at the AMA. Friends from other states comment, "Now wait a minute, you have five delegates from Kentucky and four physicians in leadership. There's some problem here." Obviously, we stay quiet about that. I'm sure the other three would agree with me that this directly results from the following winning combination. Number one, a state association that keeps us aware of important issues affecting our profession. We cannot accomplish all that needs to take place only in Kentucky—we also need support at the AMA level. Our senior AMA delegate from Kentucky, Dr Donald Barton, has earned great respect from AMA delegates throughout the country through his hard work over the years. Without his political influence none of us could be elected to AMA leadership positions. Number two, tremendous staff support. It takes a lot of time and expense just to be elected, and we get tons of support from Kentucky physicians, the Alliance, and KMA staff. Many states aren't doing that for their leadership people. Number three, big support, not only in terms of moral support from physicians around the state, but also financial support. After all, it costs something to have people in AMA leadership. Those of us fortunate enough to serve in leadership roles fully recognize and appreciate the support we receive from our colleagues, fellow Kentucky delegates, spouses, and KMA staff.

Interview and photos by Sue Tharp, Managing Editor, JKMA.

RETROSPECTIVE ANALYSIS OF PATIENTS WITH PRIMARY FALLOPIAN TUBE CARCINOMA TREATED AT THE UNIVERSITY OF LOUISVILLE

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Medical records of patients diagnosed with primary fallopian tube carcinoma between 1979 and 1989 were reviewed. Twenty-six patients were eligible; 8 patients were excluded after pathologic review, leaving 18 patients included in the study for this analysis. The median and mean age were 61 and 59 years, respectively, with a range of 39-80 years. There were three Stage I, five Stage II, seven Stage III, and three Stage IV patients. The most common presenting symptoms were abdominal/pelvic pain, abdominal

distension, and vaginal discharge/bleeding. The primary site of the lesion was determined to be the right tube in 44% of the cases, the left tube in 39% of the patients, bilateral lesions in 11% of the patients, and indeterminate in 6%. Histologic grade was poorly differentiated (Grade III) in 13 patients, moderately differentiated (Grade II) in 4 patients, and well differentiated (Grade I) in one. No patient was correctly diagnosed preoperatively. Survival at 5 years of the entire group was 35% with a 3 year minimum followup. Corresponding disease free survival was 30%. Mean and median survival times were 74 and 37 months, respectively. The range of survival times was from 1 to 120 months. All Stage I patients, 80% (4/5) of Stage II, and 29% (2/7) of Stage III patients are alive without disease. None (0/3) of the Stage IV patients are alive. Treatment regimens consisted of intraperitoneal P-32, external beam radiotherapy, and/or chemotherapy. Radiotherapy was asso-

ciated with a low incidence of treatment-related complications, the majority being gastrointestinal related. There was one chemotherapy-related death. These patients and their treatment outcomes add to the data base of numerous previous reports on fallopian tube carcinoma. Stage I and II patients fared excellently with primary surgical and adjuvant therapy. While the prognosis of Stage III and IV patients is much worse, significant levels of long term survival can be achieved with aggressive treatment.

PPrimary fallopian tube carcinoma is a rare histopathological entity comprising 0.18%-1.6% of primary gynecologic malignancies.¹⁻⁴ It was first described by Renaud in 1847,⁵ with the first genuine case report submitted by Orthman in 1888.⁶ Approximately 1300 cases have been reported to date in the literature.⁷ These tumors are seldom diagnosed preoperatively, as their onset is typically quiet, and early diagnosis is often by chance. Surgery remains the primary initial treatment with numerous studies describing various adjuvant treatments.^{7,8-11} Various staging systems, surgical approaches, grading systems, and post-operative treatment regimens have been advocated. No consensus has been reached regarding the optimal treatment of this malignancy. This review will outline our experience with 18 patients diagnosed with fallopian tube carcinoma treated at our institution. Patient presentation, staging, and adjuvant therapy are examined. Comparisons are made with the literature, and treatment recommendations discussed.

MATERIALS AND METHODS

The tumor registries of the Brown Cancer Center, University Hospital, and Alliant Hospital System were accessed, which generated 26 patients with the diagnosis of primary fallopian tube carcinoma treated at the Brown Cancer Center. Hospital and office records were analyzed retrospectively for history, presenting signs/symptoms, therapeutic modality, sites of failure, and survival. Follow-up was obtained in all cases. Pathologic criteria, including histopathology, were independently reviewed on 25 patients. Seven patients were excluded due to reassignment to other gynecologic primaries, and one patient was excluded because pathology slides were not available for histologic confirmation. Diagnostic criteria for inclusion in this study were those of Hu et al, modified by Sedlis and Yoonessi¹¹⁻¹³ (Table 1). Histologic grading was according to the modified Hu system,¹² which is similar to the FIGO grading system for endometrial carcinoma. Grade 1: pure papillary well-differentiated; Grade 2: moderately differentiated with portions of solid tumor; Grade 3: undifferentiated or predominantly solid carcinoma. All patients were retrospectively staged according to the modified FIGO surgical staging classification. Surgery in most instances consisted of an exploratory laparotomy, total abdominal hysterectomy, bilateral salpingo-oophorectomy, omentectomy, tumor debulking, and nodal sampling. Pelvic and peritoneal

Table 1. Criteria for Histologic Diagnosis of Primary Fallopian Tube Carcinoma

1. The main tumor is in the tube and arises from the endosalpinx.
2. Histologically, the pattern reproduces the epithelium of the mucosa and often shows a papillary pattern.
3. If the wall is involved, the transition between benign and malignant tubal epithelium should be demonstrable.
4. The ovaries and endometrium are either normal or contain less tumor than the tubes.

After Hu et al,¹² Sedlis,³⁴ and Yoonessi.¹¹

Table 2. Presenting Symptoms of Fallopian Tube Carcinoma Patients

Abdominal/Pelvic Pain	9
Vaginal Discharge/Bleeding	6
Bloating/Ascites	6
Peripheral Edema	3
Nausea/Vomiting	2
Gastritis/Indigestion	2
Respiratory Symptoms	2
Vaginal/Uterine Prolapse	2
Abnormal Pap	1
Urinary Frequency	1

washings were performed in the majority of patients. Survival curves were computer generated and the statistical analysis was done using the BMDP statistical package.

The 18 patients studied had a median and mean age of 61 and 59 years, respectively, with a range of 39-80 years. The obstetrical history was not recorded for 4 patients, and of the remaining 14 patients, only 1 was nulliparous. Fourteen patients (77%) were post-menopausal, and 4 (22%) were pre-menopausal. Abdominal/pelvic pain, abdominal distension, and vaginal bleeding/discharge were the most common presenting symptoms seen in 10, 6, and 6 patients, respectively. Peripheral edema, GI/GU complaints, and respiratory complaints were the next most common presenting symptoms; 1 patient presented with an abnormal pap smear. One lesion was diagnosed incidentally at surgery to correct for uterine prolapse (Table 2). The diagnostic triad of pelvic pain, vaginal discharge, and a palpable pelvic mass as described by Sedlis,¹³ was not noted in this review.

Pathologically, the right tube was involved in 44% of the cases; the left tube in 39% of the cases. Bilateral tube involvement was noted in 11% of the cases, while laterality could not be determined in one case (6%). Pathological review revealed 13 poorly differentiated (Grade 3/3) lesions, 4 moderately differentiated (Grade 2/3) lesions, and 1 well-differentiated (Grade 1/3) lesion (Table 3). All cases were adenocarcinomas except for 1 mixed mesodermal tumor. Lymph node involvement, lymphovascular inva-

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Table 3

Patient #	Lymph Node Status	Necrosis (1-4)	Inflammation (1-4)	Desmoplasia (1-4)
1	NS	1	1	1
2	—	2	2	2
3	NS	3	2	1
4	NS	1	1	2
5	NS	1	1	1
6	+PA	2	1	2
7	—	1	1	2
8	—	2	2	2
9	—	3	2	3
10	—	1	1	1
11	—	3	3	2
12	+LVI	2	4	3
13	NS	3	3	3
14	—	1	1	1
15	NS	2	2	2
16	NS	3	3	2
17	VI	1	1	1

*NS = None submitted

#PA = Para-aortic lymph nodes

@ LVI = Lymphovascular invasion

VI = Vascular Invasion

sion, necrosis, inflammatory response, and desmoplasia were analyzed in 17/18 patients. Seven patients had negative lymph nodes, 2 lymphovascular invasion, 1 patient positive pelvic nodes, and 1 patient positive para-aortic lymph nodes. Lymph nodes were not submitted in 7 patients. Seven patients had grade one necrosis, 5 grade 2, 5 grade 3, and no patients had grade 4 necrosis. Eight patients demonstrated grade 1 inflammation, 5 grade 2, 3 grade 3, and one grade 4. Grade 1 desmoplasia was present in 6 patients, grade 2 in 8, grade 3 in 3, and no patients had grade 4 desmoplasia.

MANAGEMENT

All patients surgically underwent at minimum a total abdominal hysterectomy and bilateral salpingo-oophorectomy. The majority (17/18) underwent a formal staging procedure with tumor debulking. All patients were treated with

adjuvant radiotherapy and/or chemotherapy/hormonal therapy. Radiation was administered in 12/18 patients at some point during their treatment. Radiotherapy consisted of either: (1) intraperitoneal instillation of 15 mCi chromic P-32 (5 patients); (2) pelvic external beam radiotherapy consisting of 45 to 54 Gray at 1.8 to 2 Gray fractions using either 2 or 4 fields technique with high energy photons (7 patients); or (3) abdominal/pelvic external beam radiation therapy consisting of 30 Gray in 20 fractions to the abdomen, with a boost of 20 Gray to the pelvis with high energy photons (1 patient). Multiple agent chemotherapy was used as the initial adjuvant treatment in 12 patients. Six of the 12 patients also received hormonal therapy with Depo-Provera or Megace as part of the their primary adjuvant therapy, and 6 of the 11 patients received radiotherapy in addition to chemotherapy. Platinum-based regimens were utilized in 9/12 patients that received chemotherapy. Of the 9 patients with documented recurrences, 5 received chemotherapy, 4 hormonal therapy, and 3 surgery, as part of their salvage regimens. Three patients were not treated for their recurrent disease (Table 4).

RESULTS

Stage I

The three patients presenting with Stage I disease were treated with primary surgery followed by adjuvant treatment consisting of P-32 (2 patients) or pelvic radiotherapy (1 patient). Both of the patients treated with P-32 recurred; one intra-abdominally, and the other in the abdominal surgical incision. Both patients were salvaged with surgery and chemotherapy. At the time of data analysis, all Stage I patients are alive without evidence of disease.

Stage II

Five Stage II patients received adjuvant treatment with either P-32, or pelvic radiotherapy with chemotherapy +/- hormonal therapy. The two patients who received adjuvant P-32 are alive without disease 39 and 60 months after

Table 4. Patient Characteristics: Fallopian Tube Carcinoma

Stage I								
Age	Grade	Histology	1st TX	Dose/FX (Gy, mCi)	Patient Status	Location Recurrence	Tx Recurrence	Survival Months
47	III	Mixed Pap/Solid	S, P-32	15/1	NED	ABD	S, CTX, H	116
67	III	Adeno	S, P-32	15/1	NED	Incisional	S, CTX, H	58
67	I	Pap Adeno	S, PXRT, CTX (P, ALK)	5.04/28	NED	NED	—	107
Stage II								
Age	Grade	Histology	1st TX	Dose/FX (Gy, mCi)	Patient Status	Location Recurrence	Tx Recurrence	Survival Months
66	II	Adeno	S, P-32	15/1	NED	NED	—	39
53	II	Pap Adeno	S, PXRT, CTX (P, ALK)	5.04/28	NED	NED	—	120
45	II	Adeno	S, P-32	15/1	NED	NED	—	60
54	III	Pap	S, PXRT, CTX (PAC)	5.04/28	NED	NED	—	49
61	III	Adeno	S, CTX (FAC), H	—	DOD	ABD	S, CTX, H	58
Stage III								
Age	Grade	Histology	1st TX	Dose/FX (Gy, mCi)	Patient Status	Location Recurrence	Tx Recurrence	Survival Months
68	III	Mixed Pap/Solid	S, PXRT, CTX (C), H	50/25	DOD	ABD	CTX	12
39	III	Mixed Pap/Solid	S, H, CTX (PAC)	—	DOD	DM	CTX	10
56	III	Mixed Pap/Solid	S, P-32, H, CTX (PAC)	15/1	NED	NED	—	65
80	III	Mixed Pap/Solid	S, H, CTX (PC)	—	DOD	—	—	5
64	III	PAP	S, WART	49.75/35	DOD	Pelvis	—	15
58	III	Pap/Solid Mixed	S, PXRT	54/30	NED	NED	—	70
60	II	MMT	S, PXRT, CTX (VAC)	45/25	DID	NED	—	97
Stage IV								
Age	Grade	Histology	1st TX	Dose/FX (Gy, mCi)	Patient Status	Location Recurrence	Tx Recurrence	Survival Months
61	III	Mixed Pap/Solid	S, H, CTX (PAC)	—	DOD	ABD	—	25
62	IV	Pap Adeno	S, CTX (PC)	—	DOD	—	—	1
47	III	Solid Adeno	S, CTX, (PAC)	—	Renal Failure	DM	H	37

KEY: A = Adriamycin

Adeno = Adenocarcinoma

ALK = Alkeran

C = Cytosan

CTX = Chemotherapy

DID = Dead of intercurrent disease

DOD = Dead of disease

F = 5-FU

H = Hormones

MMT = Mixed Mullerian tumor

NED = No evidence of disease

P = Cis-Platinum

Pap = Papillary

PXRT = Pelvic radiotherapy

S = Surgery

WART = Whole abdominal radiotherapy

diagnosis. Two patients received post-operative adjuvant chemotherapy and pelvic radiotherapy and are alive NED at 49 and 120 months. One patient received post-operative chemotherapy consisting of 5-FU, Adriamycin, and Cytosan, in addition to hormonal therapy. She developed an abdominal recurrence and died 58 months after diagnosis.

Stage III

Seven patients had Stage III disease. Adjuvant treatment was with chemotherapy, radiation, or both. Three patients remained NED. There was no association between treatment modality and outcome. The one patient in this series diagnosed with a Mixed Mullerian Tumor was found to have positive pelvic lymph nodes and rectal invasion at the time of initial surgery. She was treated with pelvic radiotherapy and Vincristine, Adriamycin, Cytosan chemotherapy. She died of lung cancer at 97 months from diagnosis NED with respect to her fallopian tube tumor. The other four patients who presented with stage III disease died between 5 and 15 months after diagnosis despite aggressive treatment. The patient who died 5 months after diagnosis was 80 years of age, and was taking chemotherapy at the time of her demise. It was assumed that she died of disease, as there were no complications related to chemotherapy recorded in the medical record.

Stage IV

Of the three Stage IV patients in this series, all were treated with platinum-based chemotherapy. None of the patients received radiation. The one chemotherapy-related death in this review occurred in a patient who underwent exploratory laparotomy followed by PAC chemotherapy. She died 1 month after diagnosis secondary to chemotherapy-induced renal failure. The other two patients treated with post-operative platinum based chemotherapy survived 25 and 37 months after diagnosis. Both patients died of progression of their fallopian tube cancer.

DISCUSSION

Fallopian tube carcinoma is a rare gynecologic malignancy that is seldom diagnosed pre-operatively.¹⁴⁻¹⁸ The most common presenting symptoms found in this cohort of patients were abdominal/pelvic pain, and vaginal discharge/bleeding. These findings are in keeping with reports from other institutions,^{4,8,9,11,17,19,20,21} and lend support to entertaining a diagnosis of fallopian tube cancer in patients with the diagnostic triad of a palpable pelvic mass, pelvic pain, and vaginal discharge as reported by Sedlis. Although this diagnostic triad was not present in any of the patients in our series, as many as 57% of patients have been noted to have these symptoms at presentation.¹⁷ However, it should be kept in mind that most reported incidences of the triad of Sedlis are in the range of 0-23%, and more consistent with the findings of our group of patients.^{8,9,11,22-25}

As primary fallopian tube carcinoma is a rare disease, there are few large series. Most reports come from single institutions with small numbers of patients. This series adds 18 to the growing number of reported primary fallopian tube carcinomas, and contributes to the published data base of fallopian tube carcinoma and its treatment.

In this series, stage was found to be of prognostic significance both with respect to survival and disease specific survival. The prognostic significance of stage emphasizes the importance of thorough and complete surgical staging both for prediction of outcome as well as therapeutic approach to this disease entity. Surgical staging should include an adequate incision, total abdominal hysterectomy/bilateral salpingo-oophorectomy, omentectomy, examination and palpation of the entire abdomen, and pelvic/peritoneal washings. As Tamimi and Figge have reported a high frequency of nodal metastases to the pelvic and para-aortic lymph nodes (33%) even in early stage disease, a lymph node dissection should also be performed in addition to the above staging procedures. This is further supported by Amendola's and later Maxson's findings that nodal involvement is a prominent

feature of recurrent disease.^{23,26} Maxson's 36% para-aortic lymph node positivity in recurrent disease is remarkably similar to Tamimi's figures for primary fallopian tube carcinoma. Whether or not maximum surgical tumor debulking should be attempted is unclear. There is no evidence that more aggressive surgical debulking increases survival in fallopian tube cancer, but most authors advocate this approach in a manner similar to that of ovarian cancer.^{4,11,27}

Although fallopian tube carcinoma and ovarian cancer appear to spread in a similar fashion, there are noteworthy differences which bear mentioning. Fallopian tube carcinoma tends to present at an earlier stage than ovarian cancer. This is due in large part to more frequent and earlier complaints of abdominal pain as compared to ovarian cancer, as well as a greater incidence of disease localized to the pelvis at diagnosis.^{28,29} While approximately 70% of fallopian tube cancer is localized to the pelvis at presentation, this is found in less than 40% of ovarian cancers.

As opposed to stage, tumor grade is felt to be of questionable prognostic value. There are reports which substantiate a correlation between grade and survival,^{16,30} while others do not.^{10,20,25} In this series, high grade lesions were much more common than low or moderate grades (72% vs 28%). Due to this skewed distribution, there were insufficient patients in this series to assess the effect of grade on prognosis. The series reported by McMurray⁴ contained 43% grade 3 versus 39% grade 1, while Brown⁸ and Benedet²⁷ report a predominance of high grade lesions as does this series. This is in contrast to Yoonessi's report which found fewer high grade lesions compared to low.¹¹ The prognostic significance of grade, and the relative incidence of high grade to low grade tumor types remains to be resolved.

Age, menopausal status, parity, and laterality of lesions in fallopian tube carcinoma have all been scrutinized in the literature. Our median age of 61 years is somewhat higher than that reported in the literature, but still compares favorably to that of other authors.⁴ In Yoonessi's review, the majority of patients were found to be between 45-55 years of age.¹⁶ Sixty-four per-

cent of the patients in his series were postmenopausal, as opposed to the approximately 50% reported by Corscaden³¹ and Hayden.³² The increased median age in our series correlates with the higher rate of 77% of patients who were postmenopausal in our patient cohort.

Only 1 of 14 (7.1%) patients with recorded obstetrical histories in this series was found to be nulliparous. This is much lower than the incidences in other reports, but there is wide variance in literature with a range from 21% to 71%.^{11,17,25,33} Parity generally is not felt to be of prognostic import, but Hanton did find a better survival rate in G₀ versus G₊ patients.

Laterality of tubal involvement is approximately equal in most series, with the incidence of bilaterality ranging from 8% to 26%.^{4,11,19,25,34-37} Our findings of 44% for the right tube, 39% for the left, and 11% in both tubes are consistent with those of the above references. The finding of bilaterality in a specimen is not felt to affect prognosis in and of itself.^{36,37}

The diagnostic value of a Pap smear in fallopian tube carcinoma is limited. Only 1 of 18 patients in this report was found to have a positive Pap smear, even though this was the patient's primary presenting sign. The incidence of positive Pap smears in fallopian tube cancer generally is found to be between 0-13%,^{17,25,38,39} although Sedlis reported an incidence of 60%.³⁴

Five-year survival for all stages in this series was 53% (Figure 1). Mean and median survival times were 74 and 37 months, respectively, with a range from 1 to 120 months. Minimum follow-up was 3 years. When Stage I and II were compared with Stage III and IV, overall survival was 83% versus 30%, respectively. This is statistically significant with a p-value of .01 using the Mantel-Cox analysis (Figure 2).

As fallopian tube cancer appears to be a malignancy with tendencies toward late relapse, disease specific survival should also be examined. Disease specific survival for all patients was 50% at 5 years (Figure 3). When comparing Stage I/II with III/IV, the disease specific survival at 5 years was 75% and 30%, respectively, with a p-value of .02 (Figure 4).

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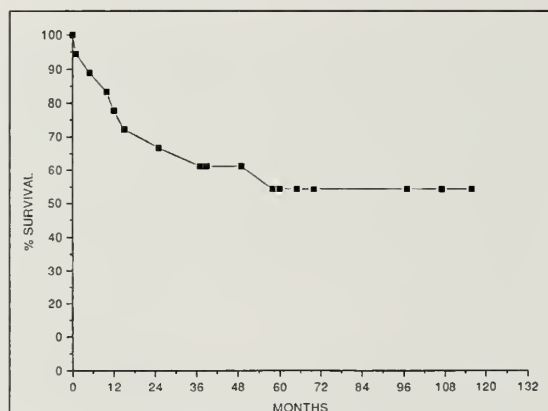


Figure 1: Fallopian Tube Carcinoma Survival.

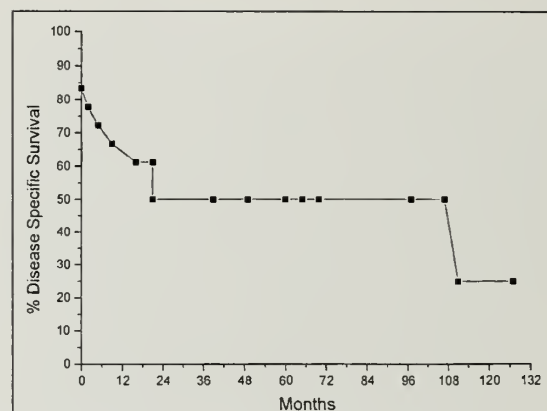


Figure 3: Fallopian Tube Carcinoma Disease Specific Survival.

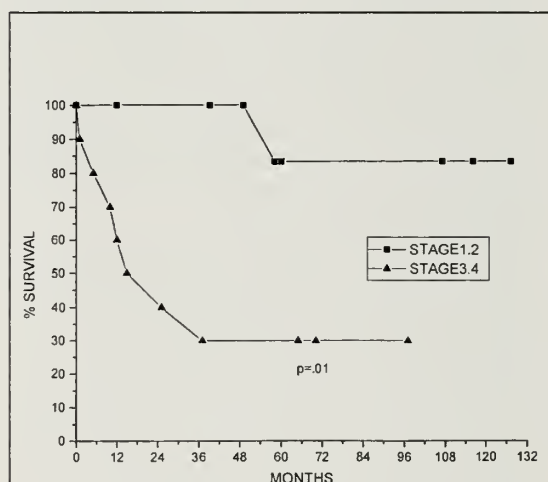


Figure 2: Fallopian Tube Carcinoma Survival by Stage.

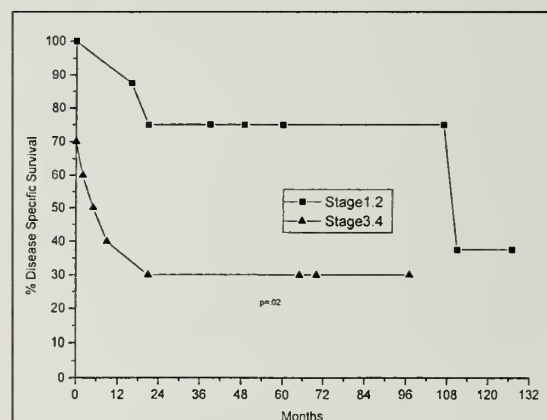


Figure 4: Fallopian Tube Carcinoma Disease Specific Survival by Stage.

While these data have not completely matured, they compare favorably with those of other series (Table 5). As is evident from these data, both overall and disease specific survival are influenced by stage at presentation. The patients included in this analysis were all treated with multiple post-operative adjuvant treatment regimens. Due to the small numbers, the role of radiation therapy and chemotherapy cannot be assessed statistically.

Although some authors report few deaths or recurrences after 3 years from diagnosis,^{19,34,40} late recurrences after 5 years have been noted to be common as observed in this series.^{8,10,22}

Yoonessi has reported 2/39 patients experiencing recurrences as late as 10 years after diagnosis.¹¹ Delayed recurrences such as these suggest that 5-year survivals may not fully reflect the effectiveness of therapy. Most series in the literature are reported at 5 years follow-up, therefore longer observations of survival and failure patterns are required to better describe the outcomes of therapeutic modalities for fallopian tube carcinoma.

Radiotherapy has been incorporated as an adjuvant treatment and is reported to increase disease free survival in a number of series.^{4,7,17,27,40-43} All patients in this review who presented

with Stage I or Stage II disease received radiotherapy either by P-32, pelvic radiotherapy, or combined chemotherapy and radiotherapy. The trend to use intraperitoneal P-32 is based on the tendency for fallopian tube carcinoma to spread intraperitoneally, as well as the more extensive use of second look laparotomy to assess chemotherapy effectiveness. This treatment approach parallels the manner in which ovarian carcinoma is treated. These results for early stage fallopian tube cancer are tempered by two Stage I patients who received intraperitoneal P-32 and developed late recurrences. Both these patients were treated with surgery and salvage chemotherapy, and are currently NED.

All Stage III and Stage IV patients were treated with adjuvant chemotherapy and/or radiotherapy. In some instances, patients were treated with a combination which included hormonal treatment. These patients' overall prognosis is comparable to results obtained in ovarian cancer, and corroborates previous reports.

It is controversial whether post-operative radiotherapy is beneficial. There are a number of series which have demonstrated an improvement from adjuvant radiotherapy,^{12,13,17,41,44-46} and others which question this practice on a routine basis.^{16,25,32,47,48} Recurrences are common, even in Stage I as manifest in this series and others.⁴⁹ While some authors recommend surgery alone for selected cases of Stage I disease,^{10,50} we would recommend a more aggressive postoperative adjuvant course of therapy. Pelvic radiotherapy alone is advocated by some authors for Stage I/II disease,^{27,51} but discouraged by others in favor of whole abdominal radiotherapy with pelvic boost (WART)^{4,39,41,50} due to the above described patterns of relapse.

WART was used in only one patient in our series, and that patient relapsed in the pelvis. One patient with Stage II disease did not receive radiotherapy, and relapsed in the abdomen, while another patient with Stage III disease experienced a similar recurrence after receiving pelvic radiotherapy. Both of these relapses could potentially have been addressed by WART. Roberts and Lifshitz¹⁹ found no benefit to postoperative pelvic radiotherapy in

Table 5. Survival Rates in Patients with Fallopian Tube Carcinoma in Selected Series

Reference	Year	# of Patients	5-Year Survival Rates (%)		
			Stage I	Stage II	Stage III
Raju ⁵²	1981	22	57	58	25
Roberts and Lifshitz ¹⁹	1982	102	77	42	6*
Deham and MacLennan ¹⁰	1984	40	69	39	29
Eddy, et al ⁹	1984	71	40	40	5*
McMurray ⁴	1985	30	59	44	29
Brown ⁸	1985	17	60	66	16*
Rosen ⁶¹	1994	115	50.8 [‡]		13.6*
Peters ¹⁰	1988	115	61	29	17
Current Series	1995	18	80% [‡]	—	30%*

[‡] Stage I and II

* Stage III and Stage IV

Stage I/II disease. Local recurrence rates were 38% when no gross residual disease was present after primary surgical therapy. Larger radiotherapy fields may have decreased this incidence as many of these failures were intraabdominal.

Transcoelomic spread is a major cause of treatment failure, but can be decreased with appropriate radiotherapy.⁵¹ While whole abdominal XRT might be excessive in patients with Stage I disease, P-32 could address microscopic disease with minimal toxicity. Benedet used P-32 without complications in two patients when no macroscopic disease remained after primary therapy.²⁷ This approach was also well tolerated in our series. P-32 in this setting requires further follow-up and investigation, but should be considered. When P-32 is not used, WART is advocated over pelvic radiotherapy alone as supported by the Mayo Clinic data which suggests an increased survival in patients with limited disease treated with WART.^{42,43} Washington University analyzed patterns of recurrence in 51 patients. One-half of these recurrences were extraperitoneal in Stage I/II patients, while all Stage III patients initially failed intraperitoneally.⁴ This would suggest that combined modality therapy (including chemotherapy) should be considered in Stage I/II disease, and would be beneficial in more advanced disease. Radiotherapy with chemotherapy could help to decrease the incidence of

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both local and distant metastases in advanced disease, and is advocated in these settings.

Our data also suggest that combination chemotherapy is more efficacious than single agent treatment, as has been reported previously.^{8,27,52-56} Although effectiveness of chemotherapy (particularly Platinum-based regimens) remains to be completely evaluated, it continues to be of considerable importance in patients who present with initial bulky disease, as well as recurrent disease. Until further investigational studies can be performed in this disease, we would advocate a treatment approach similar to that of ovarian cancer.

Use of hormonal agents has been studied by some and have been recommended because of their low toxicity profile. However, no firm conclusions have yet been reached with regard to the use of progestational agents.^{11,18,37,57} Although hormonal agents were used in most patients in this series, it is impossible to ascertain their effectiveness with the patients who were treated in this manner. However, as the toxicity profile of these agents is low, we would advocate their routine use in all advanced disease, and in most cases of early disease.

Treatment complications seen in this series were relatively minor, except for one episode of renal failure which resulted in a chemotherapy-related death. This occurred in a patient with considerable tumor bulk and symptomatic ascites. The other treatment-related complications were due primarily to external beam radiotherapy and consisted largely of diarrhea and ileus. There were two instances of cystitis related to external beam radiation. Radiation therapy was well tolerated in these treatment settings, with few if any morbidities compromising overall adjuvant therapeutic regimens (Table 6).

There was one Mixed Mullerian Tumor in our series. Approximately 50 cases of this extremely rare disease entity have been reported in the literature to date.⁵⁸⁻⁶⁰ Prognosis is poor, and long-term survival in advanced disease unusual. The patient in this report is remarkable in that she achieved long-term NED survival (97 months), prior to succumbing to other disease. This case would lend support to com-

Table 6. Complications: Fallopian Tube Carcinoma

Gastrointestinal	
— Diarrhea	4
— Ileus	1
— Short Bowel Syndrome	1
— Enterocoele	1
Genitourinary	
— Cystitis	2
Gynecologic	
— Vaginal Stenosis	1
Other	
— Renal Failure Secondary to Chemotherapy	1

bined modality aggressive therapy in the treatment of advanced stage uterine sarcomas.

CONCLUSION

This series adds to the data base of patients diagnosed with primary fallopian tube carcinoma. Preoperative diagnosis is difficult due to this tumor's infrequent occurrence and inaccessibility to physical exam. Because of the small number of patients reported in this series, it is impossible to delineate any treatment regimen that is superior to another. The optimal therapeutic approach needs to be established with further studies. In the absence of these studies, one might extrapolate treatment rationale from the ovarian carcinoma experience with hopes of making improvements in treatment outcomes.

The initial treatment approach should include a complete and thorough surgical staging procedure as in ovarian cancer. The extent and volume of tumor must be completely assessed, and notations made as to the amount of postoperative residual disease. It is unclear as to whether aggressive debulking is beneficial. Aggressive multi-modality therapy appears to improve outcome, and should be considered even in early stage disease. More extensive work needs to be done with patients who present with advanced disease (Stage III and Stage IV). Some durable long-term remissions, and even cures are achieved with aggressive management.

Surgery alone produces a high relapse rate even in early stage disease. This suggests that the use of whole abdominal radiotherapy or P-32 might be beneficial toward achieving local control. The therapeutic gain obtained by the use of less extensive fields is unclear, but should be discouraged in light of recurrence patterns seen in ovarian cancer. The optimal chemotherapeutic regimen, and its role in fallopian tube carcinoma, remains to be defined. Cis-Platinum based regimens appear to provide the highest response rates. Hormonal therapy is associated with low risks of toxicity and should be used liberally with all advanced cases of fallopian tube carcinoma, and probably in most cases of early stage disease. Earlier detection of fallopian tube cancers would enhance overall survival as demonstrated by the data presented, but as yet there are no proven cost-effective screening procedures for this malignancy.

The success of the pediatric tumor cooperative groups for treating rare malignancies should be noted by health care providers who treat patients with fallopian tube carcinomas. Pediatric cooperative ventures have yielded significant treatment advances for relatively rare diseases. The treatment of primary fallopian tube carcinomas might very well parallel these successes with more systematic treatment and multi-institutional treatment regimens.

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MR IMAGING OF ACUTE TRANSVERSE MYELITIS

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Magnetic resonance imaging has proven to be useful in the diagnosis of spinal cord pathology. Little has been written in the literature concerning magnetic resonance imaging of acute transverse myelitis. A case of magnetic resonance imaging of acute transverse myelitis in a young man with known systemic lupus erythematosus is presented along with a review of the radiographic approach to transverse myelitis.

Magnetic Resonance Imaging (MRI) has proven to be useful in the diagnosis of spinal cord pathology.¹ The range of disease processes apparent on MRI is quite extensive and includes acute transverse myelitis (ATM). ATM is associated with viral illnesses, collagen vascular diseases, demyelinating processes, toxins, vascular insufficiency, radiation therapy, and paraneoplastic disorders.²⁻⁵ Little has been written in the literature concerning MRI of ATM.^{2,6-8} A case of MRI of ATM in a young man with known systemic lupus erythematosus (SLE) is presented.

Case Report

The patient was a 25-year-old black male with a 7 year history of SLE. He was anti-cardiolipin positive and had a history of lower extremity, deep venous thrombosis. He had been off Coumadin for 3 months. His only admission medication was one aspirin a day. He presented with a 1 day history of left lower extremity weakness and a 3 day history of decreased pain and temperature sensation in the right lower extremity. Proprioception and vibratory sense were intact. Pain radiating to the right buttock and lower extremity was also a major complaint. The level of involvement was felt to be at T6. He denied bladder or bowel symptoms. Neurologically, he was found to have a Brown-Séquard syndrome at approximately the T6 level. He had no physical signs of active vasculitis. A lumbar puncture was non-diagnostic.

An MRI scan of the thoracic and lumbar spine was obtained. The T1 weighted (SE TR 678, TE 30) sagittal images showed a diffusely enlarged cord from the level of T1 through T5. The T2 weighted (SE TR 1800, TE 100) sagittal images showed central, fusiform high signal intensity at the same level (Figure 1A). T2 weighted axial images confirmed these findings (Figure 1B). No evidence of disc infection, disc protrusion, or epidural hematomas was found. No contrasted images were obtained at this time. The lumbar scan was normal. The differential included intramedullary tumor versus transverse myelitis.

The probable diagnosis of ATM was made by the exclusion of hemorrhage, disc disease, and given the association of ATM with SLE.^{6,8,9} Cytoxan pulse therapy was begun at day 5. A contrast-enhanced scan was obtained on hospital day 8, after the patient had regained much strength while on both steroids and Cytoxan therapy. No contrast enhancement was seen. The patient was discharged by the middle of the second week on oral steroids and monthly Cytoxan therapy. He had residual paresis of his left lower extremity.

DISCUSSION

MRI has shown to be an excellent noninvasive diagnostic tool for evaluating patients with spinal cord symptoms. The list of disease processes which could be accurately diagnosed include traumatic, degenerative, neoplastic, and inflammatory lesions.¹ ATM is an inflammatory entity associated with viral illness, neoplastic disorders, demyelinating processes, various toxins, vascular insufficiency, radiation therapy, and collagen vascular disorders.²⁻⁵ ATM is an uncommon but documented complication of

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Figure 1A: T2 weighted (SE TR 1800, TE 100) sagittal image showed diffusely enlarged cord from the level of the first through 5th thoracic vertebra with central fusiform high signal intensity. (Arrow)

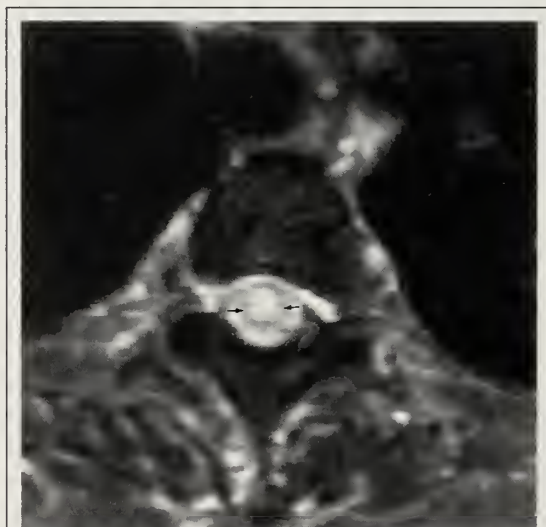


Figure 1B: T2 weighted axial image demonstrated high signal intensity of spinal cord.

SLE.^{6,8,9} Myelitis usually is a late finding but may rarely be the presenting symptom of SLE.⁷

Initial clinical features of ATM are variable and include fever, malaise, and the development of paresthesia or sensory loss in the lower limbs. Severe back or nerve root pain is also seen and has been directly correlated with the severity of the disease.⁴ The subsequent progress of the myelopathy is either limited to disease below a level, or it may ascend to higher levels. The course may fulminantly reach its maximum within minutes, or it may take weeks.⁴ Sensory loss is frequently dissociated. Total anesthesia affects only the severest of cases.⁴ Seventy-five percent develop sphincter disturbances which primarily involve micturition. A history of recent bacterial or, more commonly, viral illness is discovered in about 30%.⁵

Cerebrospinal analysis is variable. Pleocytosis is seen in about 50% and is usually monocyte predominant.⁵ Neutrophils, however, have also been noted in excess, ranging from zero to 300.^{4,5} Gilroy⁵ states that protein count is elevated in 40%. Traub⁴ reports that protein count is usually raised in the absence of pleocytosis, but is below 150mg per 100 ml in the majority. Exclusion of neurosyphilis is also urged by Taub.⁴

Radiologic analysis is crucial in making the diagnosis. Before MR, myelography was the standard examination. Myelography is usually negative but may show mild swelling of the cord. Its usefulness lies in helping to exclude acute cord compression. Because of improved delineation of bone and soft tissues, post-myelogram computed tomography (CT) examination of the spine increases the sensitivity and specificity of diagnosing hematomas, abscesses, or osseous metastasis. CT myelographic studies also provide good transaxial imaging of the cord. Another advantage is the ability to sample cerebrospinal fluid at the outset of the procedure.

Disadvantages of myelography relate to its invasive nature. Patients must be able to lie in the prone or lateral position for fluoroscopic monitoring of the lumbar or cervical puncture, respectively. With proper technique, the risk of infection is significantly decreased but is always present. Discomfort of the examination may be

due to positioning or the puncture itself. A small percentage of patients will also report a moderate to severe headache, but the use of smaller caliber needles decreases this sequela. The advantage of water-soluble intrathecal contrast agents has eliminated the need to withdraw contrast at the end of the procedure. Contrast-induced seizures are infrequent, but occur often enough that we administer steroids and phenobarbital before each examination. Allergic or anaphylactoid reactions to intrathecal iodinated contrast does not seem to be as significant a concern, even in patients with documented intravascular contrast reactions.¹¹

Where available, MR evaluation of the spinal cord should be performed. Advantages include the ability to image in three planes and the improved tissue contrast inherent to MR. MR allows one to look at the intramedullary anatomy as never before possible. Hemorrhage, infection, vascular lesions, and disc disease are also readily apparent, given the improved tissue contrast afforded by MR. New technologies and protocols have also dramatically decreased scan times. For example, phased-array coils now allow imaging of the entire cord in one series of acquisitions. The only invasive part of the examination might be placement of a heparin lock for contrast injection. The well publicized cost of MR examinations is still felt by some to be a major disadvantage. We argue that given the price of an invasive procedure such as a myelogram, which is often added to that of a post-myelogram CT, MR and its superior tissue contrast is well worth the price. Cord enlargement seen on MR images over several segments is a common finding.^{1-5,10} Enlargement of the cord is certainly not specific for ATM, but when associated with an increased signal intensity on T2 weighted imaging, the differential diagnosis includes transverse myelitis, infection, or intramedullary tumor. The clinical course, response to therapy, and cerebrospinal fluid analysis help make the diagnosis.^{1,4-6} Normalization of the cord enlargement has been

shown to occur for 12 days to one month.^{6,7} A second scan on day 8 for our patient showed near complete normalization in size. Atrophy has also been reported on T1 weighted images.¹ Response to therapy has been shown to be related not only to the diagnosis of ATM but also its severity.^{1,6,7} Our patient's lesion did not enhance, but his symptoms were markedly improved when the contrasted scan was obtained. The effect of steroids and/or Cytoxan therapy upon contrast enhancement in ATM has not been described.

ATM is a well-known neurologic entity. Its association with SLE has also been documented. This review of ATM associated with SLE presents important clinical significance.

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Stephen Z. Smith, MD

THE IRON CEILING

As medical people we have the responsibility to promote education, and specifically reading, to our patients.

To waste a mind is a terrible thing. Aging erodes some of our powers, the body loses its grip on maintaining all our abilities, and the slippage down the path of feeling useless remains a threat.

Then to see the overwhelming response of the senior community to the call for reading coaching in Jefferson County was very heartening. Perhaps no skill is more at a premium now, when employment relies less on physical prowess and more on intellectual capacity and growth, than reading. Even with the millions in other countries who illiterately struggle through meager existence, here in our midst we have thousands, probably hundreds of thousands who also have no basic reading skills, despite their native abilities. Without the teaching or maybe despite it, these people have an iron ceiling, impermeable to their attempts at ascending to a better life.

Computers, cash registers, instructions, regulations, communications, and the list goes on for the occupational requirements

to read. Personal life depends in some part on our ability to comprehend the world around us, the directions to follow and the rules to obey. We physicians assume that our medicines are recognized, that patients understand what has to be done, and that they will have the written information to review.

More people recognize the necessity for reading skills, with the state of Kentucky actively pursuing reading proficiency improvements. In the newspaper, the faces of the helping retirees and other volunteers matched the absorbing look of the students. Whatever age either of these partners in reading development, the younger helping the older, peers with each other, or more senior people tutoring their juniors, the happiness of that interchange colors the photographs and paragraphs telling of this program.

As medical people we also have the responsibility to promote education, and specifically reading, to our patients. Our

profession finds its roots deeply in the soil of reading and acquiring the written word. What is audible may not be comprehended, if the listener cannot translate this input into understandable material. Devoid of reading skills, the patient could be missing much of what is important, how to take medication, when to seek more help, what to look for on their review of systems and symptoms, and even how to contact their physician or other caregiver. As a profession and individually, we are challenged to contribute time and money to these programs, which vastly improve our community and the people for whom we care.

Stephen Z. Smith, MD

TELEMEDICINE: NEW DIRECTIONS FOR HEALTH CARE DELIVERY IN KENTUCKY SCHOOLS

To the Editor:

Telemedicine technology and services have gained the attention of both scientists and practitioners examining trends and models of health care for underserved populations and where professional consultation with a team of professionals may benefit service providers in rural communities. Examined is a model of telehealth service delivery through school systems in underserved communities of Kentucky. New systems of managed care have recognized that unequaled geographic distribution of health care resources, and the recognized need to health care provision in an economically pressed, cost effective environment necessitates new models for assessment, treatment, prevention, and consultation. Telemedicine is seen as the use of telecommunication, which connects consumer with health care provider through live, two-way audio, two-way video transmission, across distances, and permits effective diagnosis, treatment, and other health care services. This definition stresses a focus on delivery of services across distances that could be provided by the two medical schools in the Commonwealth with a sense of concern for ethical provision of services and confidentiality of the health care needs for our society.

The technology of telehealth involves interactive video transmission. Currently, two transmission modes exist: analog and digital. The analog mode, transmitted in the form of waves, is the technology of broadcast

television. Among its advantages are the high resolution of the images transmitted and its familiarity. There are disadvantages with interactive video transmission, the most prominent of which is the expense associated with transmission and the size and complexity of the hardware that is required for such efforts. The digital mode, on the other hand, takes advantage of developments in computer science and transmits in the form of a digital byte-stream of zeros and ones. Its advantages are lower transmission costs, reduced equipment size, simplicity of operation and easy interface with computers and with computerized systems. The relative disadvantages of the digital system appear to include the so-called echoes of motion that appear at slow transmission speeds. It is, however, noted that the working components of interactive video transmission are the equipment set and the transmission set itself. At the heart of this equipment is the CODEC, which is an acronym for Coder-Decoder. This equipment transforms the analog signal to a digital one at one end of the network and back again at the other. To transmit live video images, a video camera is needed at each site. It is augmented by microphone to pick up speech and other audible information so that those on each end can see and hear what is being sent to each site by the other.

At the cutting edge of the technology of telemedicine is satellite transmission. Such opportunities transcend

geographic limitations and means that interactive video systems can reach almost any location worldwide. Numerous clinical applications have been found to be useful and effective. These include:

- Initial and periodic interview and evaluation by clinician, at university medical school sites; consultations for crisis stabilization and emergency interventions; evaluations and diagnostics related to second opinions; short term case management; consultation-liaison services to parents and children; consultation with primary care physicians and/or specialists, clinicians and educators regarding students; and continuing education for administrators, faculty, students, parents on health related issues.

Technological advances in education and health care delivery have included the use of distance learning for prevention interventions, assessments, treatment, and self management skills training to rural populations. Its application to child and family services and the justice system hold great promise (Berek & Canna, 1994). Efforts to date have ranged from using closed circuit television to bringing educational programs to distance sites a few miles away as well as using satellite uplinks to provide education and training to international sites (Scott, 1994). Its application for consultation to school systems, community agencies and regional centers for prevention education and intervention services offers innovative

opportunities to address the needs of rural populations (Newhouse, 1993; Sanders & Bashshur, 1995).

Telemedicine has been considered a partial solution to the problems of delivering clinical, educational and prevention interventions to schools in remote rural areas of Kentucky as well as to areas underserved by health care professionals. Various projects have demonstrated a wide variety of clinical and educational tasks that can successfully be accomplished by telemetry and voice communication systems. The need for telemedicine delivery to schools is obvious in the face of the major obstacles to providing a universal high standard of prevention, interventions and health care delivery to all children.

Recently identified systems of managed care have recognized that unequal geographic distribution of health care resources, and the recognized need for health care provision in an economically pressed, cost effective environment necessitate new models for assessment, treatment, prevention, and consultation (PPRC, 1995). Telehealth services through the schools offer a visionary method of providing standardized and universal coverage to all children by linking metropolitan and flagship university medical schools with rural school districts. This definition stresses a focus on delivery of services across distance with a sense of concern for ethical provision of services and confidentiality of the health care needs in our society. An alternative way of providing traditional health services, tele-

health is considered by some to be a solution to America's toughest health care challenges: increasing access to prevention programs and health care while decreasing the costs involved in providing quality care (Office of Rural Health Policy, 1994).

Interactive Electronic Communication with School Systems

Kingdom (1995) wrote in a recent editorial in *Science* that addressing health care delivery through telemedicine at all levels is fundamental. Theories about the nature of knowledge and methods of education have been debated for sometime. Is knowledge a mountain of fact for the learner to conquer or is it an ever-changing stream of theories and new conceptions through which one must learn about our world? Would students master facts or develop problem-solving skills? Learning occurs most easily when the learning experience is directed toward the solving of a real problem with which one can identify, and when it uses an understandable approach in which the effectiveness of an intervention can be readily pursued. Legitimate educational projects include the real problems facing consumers, clinicians and health care and health education institutions. Solutions found in one location may be shared with collaborating institutions, facilitating exchange of information with each other. In a comment on the evolution in higher education, Abelson (8 August 1997: 747) argues: "Universities and colleges in the

United States are encountering a turbulent climate. The quality of their future in many ways depends on how well they respond to evolving realities in the larger world beyond their walls. Ultimately the most significant change effecting universities may be continuing revolution in information technology and delivery of healthcare services."

At the cutting edge of the technology for healthcare and education provision for the 21st century are a broad spectrum of services in the schools.

Telemedicine or an affective medium of health care provision through the schools will utilize interactive television and address the provision of the competency and evidence based health care to rural Kentuckians.

Kentucky Telecare: A Model for the Commonwealth

Kentucky Telecare is a network of medical care providers committed to enhancing the healthcare delivery system by overcoming the barriers of time and distance through the judicious utilization of electronic medical communication systems. It is quality healthcare unreleased by time or distance. It provides benefits to the patient including: rapid access to tertiary center; received tertiary care while remaining under the direct care of their personal physician; remain close to home where family and friends can provide support; patients are not transported to the tertiary care center unless absolutely necessary; if a transport is necessary, the

referring and receiving center may better coordinate preparation of the patient.

The cost benefits include: the most cost effective methodology for delivering high quality healthcare to underserved areas; reduced transfers to tertiary care centers keep more money in the local economy; reduced travel expenses—in 1996, Medicaid paid \$31 million for travel expenses in Kentucky. As Managed Care penetrated increases, telemedicine will facilitate cost reduction strategies.

The benefits to rural clinicians include: access to specialty/subspecialty consults on a real-time basis; easy access to continuing education opportunities without the need to travel; reduce the isolation often felt by rural clinicians/increase collegiality with the University Medical Center; allow primary care physicians to directly manage the care of their patients with support from tertiary care specialists. To learn more about the medium of telemedicine access the following web page (<http://kytelecare.uky.edu>).

Clinicians and researchers across the Commonwealth should examine the effectiveness of clinical care delivered through the schools focusing in on the following: diagnostic and treatment modalities that are best suited to electronic delivery systems; child, adolescent and adult populations that will be best served by telehealth; methods of keeping video-taped sessions and other electronic medical records secure and confidential; and suitable means of providing standardized health care services to children and families in underserved rural settings (Mahev, 1997).

Telemedicine approaches to diagnosis, consultation and treatment intervention should maximize the use of direct clinician-to-clinician and clinician-to-teacher consultation, assuring proper credentialing and professional education and training in these specific areas of consultation. Its adaptability to clinical services offers new avenues for provision of clinical care in the areas of education, consultation, administration, research, and treatment services.

Historically, educational programs including continuing education programs have provided access to health care providers for important areas of diagnostics and treatment. New avenues of health care provision, consultation and diagnosis and therapeutic management of children in the schools through supervised experiences offer us a glimpse of the cutting edge of health care delivery through telehealth for those needed services in rural Kentucky.

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 University of Kentucky
 College of Medicine*
Jean M. Miller, EdD
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ACKNOWLEDGEMENTS: The authors wish to acknowledge the assistance of Tag Heister, Deborah Kessler, Linda Brown, Celena Keel, Heather Hosford, Janeen Klaproth, Shannon Nelson, Amy Farmer, Amy Pierce, Miranda Rogers, Tina Lane, and Liza Gilkey for their contributions to the completion of this manuscript.



Jan Crase

THE PLEASURE WAS MINE

The last KMA Journal article by the President of the Alliance traditionally includes the year's accomplishments and the state of the Alliance. I have enjoyed communicating with you physicians via way of these articles throughout the year and thank you for all your positive responses and your kind support. The KMAA fiscal year runs from May 1 through April 30th, and Carolyn Daley will become President at the April Convention in Somerset. Carolyn will serve this organization extremely well and I truly look forward to her tenure. Much good will be accomplished under her leadership.

It was my privilege to have known Alex Haley who was a wonderful storyteller, and one of his favorite sayings was, "When you see a turtle on a fence post, you know it had some help in getting there." When we see substantial accomplishments of substance, we know there was help from other people. That was indeed the case with the KMAA this year. The help was unbelievable. It has been my privilege to serve for one year as the captain of a ship where every member of the crew was capable of being captain. I wish that every physician and every spouse could have walked in my shoes for only one week during this past year and experienced the

hospitality, warmth, support, concern, and kindness that has been shown to me. Physician spouses are truly some of the most caring people I know. This time last year I entered upon my duties as president with a sense of humility and today I remain even more humbled and awed by this fine organization.

The real heart of this organization is at the County level where the work is done on a person-to-person basis, and the projects are just too numerous to list in this article. County leaders go beyond their own county lines and work on the state level as well, supporting the many state programs and endeavors.

During this, our 75th year, by working as a team and forming coalitions, we helped accomplish the following on the state level:

Health Education:

- Reached approximately 88,000 teachers and staff with breast cancer awareness information in their last pay check of the year.
- Gave Alliance members packets of flower seed with sticker saying, "Mammograms can detect breast cancer when it is only the size of a tiny seed."
- Reached most of KY's public school children K-3 with SAVE anti violence materials.

It has been my privilege to serve for one year as the captain of a ship where every member of the crew was capable of being captain.

- Reached numerous groups with the SMART (Students Made Aware Reject Tobacco) program.

AMA Foundation:

- Established endowed scholarships at both the U of L & U of K medical schools.
- Raised funds for the AMA Foundation to be used for medical education & research.

Legislation:

- In preparation for the 2000 Kentucky Legislative Session, Dr Bob DeWeese conducted a Legislative workshop at the Fall Board meeting.
- Wrote a letter to each member of the Kentucky General Assembly.
- Held a Legislative Day at the Capitol in January where members attended a workshop given by the KMA lobbyist, John Cooper, and visited their Legislators prior to the Winter Board meeting.

Leadership Development:

- Many County Presidents-Elect attended AMAA Leadership Confluences in Chicago along with the State President and State President-Elect.
- Nominated State President-Elect, Dr Nancy Swikert, MD, attended Leadership Confluence II in Chicago in February.
- Sandi Frost, Nominated Vice President of Membership, attended AMAA Membership workshop in Chicago in February.
- Leadership training at the Fall Board including workshops on:
Membership
Legislation
SMART
AMA Foundation
Growing Healthy
- A Legislation workshop was conducted at Winter Board

Medical Heritage:

- Produced a Medical Heritage documentary video about Dr Louise Hutchins.
- Funds are committed for production of a Medical Heritage documentary video about Dr C.C. Howard from Glasgow.

McDowell House:

- In the process of raising funds for the McDowell House in Danville.

Doctor's Day:

- Doctor's Day was to be celebrated by getting bookmarks printed with information about osteoporosis prevention and distributed to every library in the Commonwealth.

Obviously, the Alliance is alive and well. I still have some major concerns about both the medical profession and the Alliance because we face many crossroads with so many pressures and changes occurring in medicine; however, if the family of medicine sticks together and keeps its commitment to **both patient and physician choices, quality care and services**, and maintains a commitment of **care and concern for each other**, we shall survive and be strengthened—strengthened in our relationships with patients and with each other. United we can stand. If divided, medicine and the quality of care as we have known it, will surely fall. Do we join hands and work together, or do we become victims, feel sorry for ourselves and blame others for our poor choices?

The choice is ours!

WE CAN CHOOSE TO FEEL
GOOD ABOUT OUR-
SELVES—

WE CAN CHOOSE TO MAKE
OTHERS FEEL GOOD
ABOUT THEMSELVES—

WE CAN CHOOSE TO TREAT
OTHERS LIKE WE WANT
TO BE TREATED—
WE CAN CHOOSE HOW WE
FEEL WHEN SOMETHING
MAKES US MAD—
WE CAN CHOOSE TO TELL
OTHERS HOW WE FEEL
WHEN THEY MAKE US
MAD—
WE CAN CHOOSE TO SOLVE
PROBLEMS WITHOUT
HURTING OTHERS—
WE CAN CHOOSE TO PLAY SO
THAT EVERYONE HAS
FUN—
WE ARE HAPPY WHEN WE
MAKE GOOD CHOICES—
WE MAKE OTHERS HAPPY
WHEN WE MAKE GOOD
CHOICES
WE FEEL GOOD ABOUT
OURSELVES WHEN WE
MAKE GOOD CHOICES

This is the message of the "I Can Choose" booklet the Alliance distributed to children throughout the Commonwealth as a part of the anti-violence SAVE program. Can we learn from this message also?

This year I have labored long and hard for this Alliance whose members are truly caring, hard working people—The pleasure was mine.

Jan Crase
KMAA President

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NEWSMAKERS

Good Housekeeping magazine has named three Kentucky physicians among the country's top cancer specialists for women. Named were **Mohammed Mahjuddin, MD**, chair of the Department of Radiation Medicine at the University of Kentucky College of Medicine; and the University of Louisville School of Medicine's **Hiram C. Polk, MD**, chair of the Department of Surgery, and **Susan Galandiuk, MD**, Department of Surgery.

The 318 physicians on the list were nominated by 280 department chairs and section chiefs in surgical, medical, and radiation oncology at major medical centers across the country. Physicians were not allowed to recommend any specialists from their own institutions.

In its March issue, *Good Housekeeping* lists the 318 cited most often from the 1,200 doctors named. Dr Mohiuddin is listed in the colon cancer/radiation oncologists category, and Drs Polk and Galandiuk are listed in the colon cancer/surgeons category.

Virginia T. Keeney, MD, Louisville, has been named recipient of this year's Ben Kilgore Award for Community Service. Dr Keeney has served in numerous community and philanthropic efforts.

Susan E. Spires, MD, Lexington, has been named to serve on the Practice Expense Advisory

Committee (PEAC) of the Relative Value Scale Update Committee. Dr Spires, a member of KMA's Managed Care and Cancer Committee, has been actively involved in issues of access to medical care, particularly in the areas of Pap smears and breast and cervical cancer screening and therapy. The PEAC was formed to assist with more careful analysis of the practice expense data as it pertains to the RVS.

J. David Richardson, MD, vice chair of the University of Louisville Department of Surgery, was elected president of the Louisville Surgical Society for 1999. A University of Kentucky graduate, Dr Richardson practices general surgery in Louisville. Other elections included **Charles J. Bisig, Jr, MD**, as secretary/treasurer and president-elect, and **Blaine Lewis, MD**, continued as historian. Members of the Louisville Surgical Society Board for 1999 are: **Hiram C. Polk, Jr, MD**; **Neal Garrison, MD**; **Todd Gardner, MD**; and **Earl Gaar, MD**.

Gary S. Marshall, MD, Louisville, was elected to the Society for Pediatric Research. This election recognizes Dr Marshall's research achievements and investigative independence.

Edward L.W. Scofield, MD, Louisville, a past president of the Jefferson County Medical Society, has been appointed chair of the Anthem Utilization Criteria Development and Management

Committee. This multi-state peer-review committee at Anthem Bluecross/Blueshield will review policies and procedures for the company in Kentucky, Ohio, and Indiana. The committee will begin meeting this year.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

BELL

Robert Gorrell Jr MD S
3602 West Cumberland Ave
Middlesboro 40965
1977, Hahnemann Med Col of
Philadelphia

BOYLE

Ronald Bibb Jr MD IM
218 Southtown Drive
Danville 40422
1994, U of Louisville

CLARK

Ronald Fulkerson MD PD
1300 W Lexington Ave
Winchester 40391
1975, U of Kentucky

CRITTENDEN

Debra Genesis MD FP
251 Guess Dr
Marion 42064
1992, Faculty of Med Calgary

DAVIES

Geraldo Bandel MD IM
815 E Parrish Ave Ste 410
Owensboro 42303
1984, Higher Institute of Med
Sciences Cuba

FAYETTE

Cathy Brown MD AN
205 S Hanover Ave
Lexington 40502
1982, U of Kentucky

Raeford Brown MD AN
205 S Hanover St
Lexington 40502
1980, U of North Carolina

Qi Feng MD IM
613 Winter Hill Ln
Lexington 40509-1960
1985, Shantung Provincial
Med Col

Mary Fischer MD AN
2226 Mackey Pike
Nicholasville 40356-8344
1990, Loyola U

Marie Hanna MD AN
Anesthesiology N-203 0084
Lexington 40536-0284
1985, Ain Shams U Egypt

David Hemmings MD OPH
1760 Nicholasville Road Ste 203
Lexington 40503
1994, U of Kentucky

Derek Henson MD PD
4213 Nutmeg Dr
Lexington 40513-0914
1993, U of Kentucky

Lee Hicks MD HEM
1628 Nicholasville Rd Ste 201
Lexington 40503-1425
1988, U of Louisville

Timothy Highley DO FP
2551 Richmond Rd Ste 8
Lexington 40509
1992, West Virginia U
Morgantown

Robert Hosey MD FP
660 Graviss Court
Lexington 40503
1993, State U of New York

Paul Meade MD PTH
3691 Rabbit's Foot Trail Apt 5
Lexington, 40503
1977, West Virginia U
Morgantown

Nadia Rasheed MD AN
3708 Kevin Ct
Lexington 40517
1983, U of Baghdad

David Ratliff MD AN
3653 White Pine Dr
Lexington 40514
1994, Marshall U West Virginia

Thomas Sweasey MD NS
3617 Winding Wood Ln
Lexington 40515
1985, U of Cincinnati

Valerie Taylor MD PTH
1221 South Broadway
Lexington 40504
1984, Louisiana State U

Angelia Thompson MD OPH
3901 Rapid Run Dr Apt 926
Lexington 40517
1993, U of Southern Florida

Edward Wright III MD U
240 Woodspoint Rd
Lexington, 40502
1990, Dartmouth Med School

FLOYD

Brendan McKenna MD OBG
5032 Ky Rt 321
Prestonsburg 41653
1980, Queens U of Belfast Ireland

Alok Singh MD IM
PO Box 275
McDowell 41647-0275
1994, Maulana Azad Med Col

FRANKLIN

Glyn Cardwell MD IM
275 E Main St
Frankfort 40621-0001
1966, U of Missouri Columbia

FULTON

David Watlington MD OBG
143 Kennedy Dr
Martin 38237
1994, Texas Tech U School of Med

HARRISON

Derek Clarke MD OBG
P O Box 247
Cynthiana 41031
1993, U of Ottawa

HENDERSON

Michael Mayron MD N
110 3rd St Ste 370
Henderson 42420
1975, U of Illinois Col of Med

JEFFERSON

O Ayangade-Johnson MD PD
601 S Floyd St Ste 801
Louisville 40202
1988, Obafemi Awolowo Col of
Health/Sciences

Karen Berg MD R
602 Jarvis Ln
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1987, U of Louisville

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225 Abraham Flexner Way Ste 403
Louisville 40202
1991, U of Louisville

Thomas Gabriel MD ORS
17005 Ash Hill Dr
Louisville 40245-6102
1987, Georgetown U District of
Columbia

Debra Gosser MD IM
9603 Holiday Dr
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1995, U of Louisville

Abdul Haq MD PD
1817 S 34th St
Louisville 40211
1984, Dow Med Col

Nuzhat Hasan MD PUD
530 S Jackson St ACB 3
Louisville 40202
1979, Dow Med Col

James Klemens DDS MD DENT
611 Fenley Ave
Louisville 40222
1995, U of Louisville

Alfred Knable Jr MD 310 E Broadway Ste 200 Louisville 40202 1992, Indiana U School of Med	<i>D</i>	MASON		Patricia Faulkner-Simmons MD <i>PD</i> 201 Park St Bowling Green 42101 1995, U of Louisville
Antara Mallampalli MD 2400 Mellwood Ave Apt 805 Louisville 40206-1065 1992, Northwestern U Womans Med School	<i>PUD</i>	Raghuraman Srinivasan MD 910 Kenton Station Dr Maysville 41056 1988, Seth G.S. Med Col India	<i>C</i>	WHITLEY
Kimber Sippell MD 825 Barret Ave Louisville 40204-1743 1990, Michigan State U	<i>IM</i>	MCCRACKEN		Sheena Banerjee MD <i>PD</i> 1400 Cumberland Falls Hwy Corbin 40701 1988, LTMM Col India
Joern Soltau MD 301 E Muhammad Ali Blvd Louisville 40292 1988, Heidelberg U Germany	<i>OPH</i>	Anita Fleenor-Ford MD 4447 Pines Rd Paducah 42001 1993, U of Louisville	<i>ID</i>	Ruhul Choudhury MD <i>IM</i> 1281 Huger St Jellico 37762 1980, Sylhet Med Col
Maria Veling MD 661 S Floyd Ste 700 Louisville 40202 1993, U of Louisville	<i>OTO</i>	PIKE		IN TRAINING
JESSAMINE		William Betz DO 214 Sycamore St Pikeville 41501 1981, U of Health Sciences Missouri	<i>FP</i>	FAYETTE
Thomas Coburn MD 1601 Sheely Woods Rd Nicholasville 40356 1995, U of Kentucky	<i>FP</i>	Sujata Gutti MD PO box 2158 Pikeville 41502 1987, Pandit Jawaharlal Nehru Med Col	<i>N</i>	Kathy Lee Sanders MD <i>PTH</i>
KENTON		Ghazala Quddus MD 167 Weddington Branch Rd Pikeville 41501 1977, Fatima Jinnag Col	<i>IM</i>	JEFFERSON
Troy Ashcraft DO 66 Superior Ave Ft Mitchell 41017 1998, UMDNJ New Jersey	<i>FP</i>	John Strosnider DO 214 Sycamore St Pikeville 41501 1975, Kansas City Col of Osteopathy	<i>FP</i>	Eric Lawrence Bosley <i>PD</i> Timothy S Brown MD <i>IM</i> Esperanza A Wade MD <i>AN</i>
D Louis Kennedy MD 656 Canterbury Ln Edgewood 41017 1980, U of Cincinnati	<i>C</i>	PULASKI		NORTHERN KENTUCKY
KNOX		Clyde Dabbs MD 2441 S Hwy 27 Somerset 42501 1945, Washington U	<i>S</i>	David Banks MD <i>FP</i> Eric Baumann MD <i>FP</i> Michael Bernardon MD <i>FP</i> Roger Chang MD <i>FP</i> Michael Cooper MD <i>FP</i> Jobeth Rayborn MD <i>FP</i> Douglas Smalara MD <i>FP</i>
Mirella Florella Ducu MD PO Box 1566 Barbourville 40906 1992, U of Med Bucharest	<i>IM</i>	WARREN		
LIVINGSTON		Robert Byrd MD 331 Milwood Dr Bowling Green 42104 1994, U of Louisville	<i>PMR</i>	
Ghassan Yazigi MD P O Box 345 Salem 42078 1988, Damascus U	<i>IM</i>	Grover Dils MD 696 Rivergreen Ln Bowling Green 42103-8770 1985, U of Nevada	<i>IM</i>	

OBITUARIES

Alec Spencer, MD
West Liberty, KY
1915-1999

Alec Spencer, MD, a retired general practitioner, died February 1, 1999. A life member of KMA, Dr Spencer was a 1940 graduate of the University of Louisville School of Medicine.

Hand Transplant Drew International Attention

There has been a steady stream of news coverage of the recent hand transplant surgery performed by surgeons from the University of Louisville and Kleinert and Kutz Hand Care Specialists at Jewish Hospital. Transplant team members included **Warren C. Breidenbach, MD**, a partner at Kleinert, Kutz and Associates and a U of L assistant clinical professor of plastic and reconstructive surgery; **Jon W. Jones, Jr, MD**, an assistant professor in the U of L department of surgery and the pancreas Transplant Program director for U of L and Jewish Hospital; **Gordon R. Tobin, MD**, a professor of surgery and director of the U of L division of plastic and reconstructive surgery; and **John Barker**, an associate professor of surgery and research director of the U of L division of plastic and reconstructive surgery.

Media of every kind have filed stories about the patient and the procedure. Outlets from *Newsweek* to *Scientific American*, The Associated Press to Agence France-Presse, and ABC to BBC announced the first US hand transplant. "Dateline NBC" featured the patient, Matthew Scott, as well as surgeons Jones and Breidenbach, on a segment in February, along with a promise to continue to follow the story. Local media outlets updated the story daily.

According to a report from U of L, Louisville's Hospitality TV, which made some of the early

media briefings available on satellite, reported that 150 separate broadcasts of the story reached an audience of more than 7 million viewers on the first day alone. Also, as of early February, a cumulative television audience of more than 104 million viewers in the United States had seen at least one report about the transplant.

Not included in these figures were viewers who saw comments concerning Scott's progress on "Good Morning America," nor an interview a week later with Drs Jones and Breidenbach. CNN covered the story in detail, devoting considerable airtime as well as a page on its CNN Interactive Web site.

Radio and TV personalities including Paul Harvey, Rush Limbaugh, Jay Leno, and David Letterman made reference to the event.

In print, the story went literally all over the world. In addition to The Associated Press, which ran state, national and international wire versions of the story, press agencies in France, Germany, England, Canada, Australia, Spain, Japan, and China circulated stories about the surgery.

In addition to traditional news outlets, the transplant team has for more than a year maintained a World Wide Web site to educate the public and encourage comment. The site, which recorded an average of 500 hits per month prior to the surgery, racked up more than 30,000 hits in the week following the surgery. (Each hit represents a request for a Web site page.) The

most popular Web pages by far included pictures. Fully 95% of all traffic on the site converged on pages that featured visual images.

Others took special note of the web site as well. *Scientific American* magazine's cyberpage named the site its "Current Pick of the Web." *Newsweek* magazine devoted four pages to the story in its February 8 edition. A *People Weekly* magazine reporter spent months researching and conducting background interviews for a story that appeared in the February 15 edition, and an in-depth *New Yorker* magazine article was scheduled.

For more information, visit the World Wide Web site (www.handtransplant.com).

New AMA Booklet Series Explains Medicare+ Choice

As a part of its ongoing commitment to providing service for the medical profession and strengthening the patient-physician relationship, the AMA is developing a series of booklets to help all physicians and their patients understand the Medicare+ Choice program.

The new Medicare+ Choice program, created by the government in 1997 and scheduled for implementation in January 1999, was designed to offer Medicare patients a wider range of health care coverage choices.

"The new Medicare system embraces many of the principles the AMA has been advocating for

years—including expanded choice for our patients,” said AMA President Nancy W. Dickey, MD. The new booklets offer help to America’s physicians as they begin implementing the Medicare+Choice program within their practices. The AMA hopes that the complimentary booklets will make the transition to this new system as easy as possible for physicians.

The first of three booklets in the series, “What is Medicare+Choice and Where Do Physicians Fit In,” focuses on the basics of Medicare+Choice. The booklet details differences between the “original” Medicare and the new options available under Medicare+Choice. It also describes various aspects of the new program, including contracts between plans and physicians, payment issues and rules on physician-plan relations.

Two future companion volumes, “Medicare+Choice: What You Should Say or Not Say to Your Patients” and “What You Need to Know About Providing Services to Medicare+Choice Patients,” are scheduled for publication early this year.

During this period of transition and new uncertainty for Medicare, the AMA has been active in voicing the concerns of physicians and their patients.

As Medicare+Choice evolves and as the federal government continues to work out the details of the program, the AMA will keep physicians apprised of these important changes.

The first booklet is available on the AMA Web site (<http://www.ama-assn.org/adcom/>

whatmed.htm). For additional information or to order a copy of this booklet, AMA members may call 800/262.3211.

Federal Prosecutor Discusses Fraud & Abuse, Sexual Harassment

Assistant US Attorney Marissa Ford, Louisville, said at a recent meeting of the HFMA/KMGMA that federal prosecutors are looking for “good faith” efforts by all medical providers, including physicians, to correct coding, billing and other mistakes made in their offices. She also predicted that the federal government will begin to bring more cases under the federal anti-kickback law, and that the future of health care fraud and abuse is in the area of *qui tam* cases in which a “whistle-blower” may bring a lawsuit against a medical provider for alleged fraud and abuse.

Ms Ford also indicated that sexual harassment is an area that the health care industry should address. KMA’s model sexual harassment policy for a physician’s office is on page 132 of the KMA Legal Handbook. E-mail (phelps@kyma.org) for more information.

Preparing for Y2K

KMA, along with the Kentucky Hospital Association and Kentucky Pharmacists Association, have asked all major insurance carriers and HMOs in Kentucky for assurance that their organizations have addressed

Y2K issues. The joint letter, mailed January 25th, asked each entity to respond that:

- necessary adjustments have been made to software to maintain patient and provider information;
- continuation of payments to providers would be assured in a timely fashion, and
- they had received documentation from their software vendors/suppliers of Y2K compliance.

Responses on Y2K readiness plans have been received from the following entities: Anthem, CHA Health, HealthStar, Medco Review and Medco Value Plus, and MultiPlan.

If you wish to receive a copy of a particular plan, please notify KMA by phone or e-mail (member@kyma.org).

Also, a Y2K guidelines manual is available as a member benefit for free download in the members only section of the **AMA Website** (<http://www.ama-assn.org>).

Hard copies of the manual are available for \$25.00 for **AMA members** and \$100.00 for non-members by calling 800/621.8335.

Aetna Announces Coverage Review System

Aetna recently announced a national policy under which patients denied coverage will be able to have the decision reviewed by outside experts. How external review might be implemented in Kentucky has not yet been announced.

KEMPAC Ends 1998 With a Membership Gain

Kentucky was one of seven states that met or exceeded their AMPAC Membership goal for 1998. Nearly one-half of the other states in the Federation did not meet their goal or exceed their membership. KEMPAC ended 1998 with 992 members, which represents 21% of the KMA membership.

Membership in KEMPAC/AMPAC is vital to KMA's and AMA's legislative effort by helping to support legislators who uphold medicine's political views.

AdminaStar Compiles List of Common Errors

AdminaStar Federal, the carrier for the state of Kentucky, recently compiled a list of "common errors" it finds in claims submitted by physicians. If you would like a copy of the list, contact the KMA Legal Department or email (phelps@kyma.org).

Derby Party Proceeds to Fund Diabetes Research

Sisters Patricia Barnstable Brown (wife of David E. Brown, MD) and Priscilla Barnstable have announced that they will contribute \$1 million to diabetes research at the University of Kentucky and the University of Louisville. The gift will be used to fund an endowed chair in pediatric diabetes research at each school.

The gift, in the form of proceeds from the legendary Barnstable-Brown Derby Party, will be given in five annual increments of \$100,000. The Research Challenge Trust Fund established last year by the state legislature and Governor Paul Patton will match the gift so each university will receive a total of \$1 million.

"Speaking as a diabetes patient," said Dr Brown, "and on behalf of all diabetes patients in Kentucky, we look to the talent, knowledge, and leadership of the universities of Louisville and Kentucky to enlighten the medical community so that we can find a much-needed cure for this devastating disease." Dr Brown recently underwent a kidney transplant necessitated by diabetes complications.

The U of L gift will go to support a new program of diabetes research in the medical school's pediatrics department. **Larry N. Cook, MD**, pediatrics chair, already is involved in recruiting world-class diabetes researchers to the program. The gift also might be used to support members of Dr Suzanne Ildstad's research team working on treatments for juvenile diabetes.

New Technology Helps Expose, Treat Cancer

New technology is playing a key role in cancer treatment at the University of Louisville Hospital's James Graham Brown Cancer Center, according to a report from the University. Researchers are using three new

linear accelerators to help physicians and cancer specialists plan, practice, and deliver microscopically precise dosages of radiation treatment.

"Many cancers are still cured by radiation alone or in combination with other therapies," radiation oncology chair **William Spanos, Jr, MD**, said. "Radiation is still a recommended part of the treatment plan for 50% of cancer patients."

Once the physicians determine that radiation therapy should be part of the treatment, Dr Spanos explained, the radiation oncology team begins a complete analysis of the patient's risk areas.

Before proceeding, cancer specialists identify the lesion or tumor's location, areas that may be at risk of future cancer development, and normal tissue they should avoid damaging in the radiation therapy process.

"New equipment is important, but physician training and judgment is more important to take proper advantage of this new system's capabilities," he said. "The system is designed to be linked together for a seamless flow of information from planning to CT scan to simulation to treatment."

Team members enter this data into a treatment-planning program, which then helps them mold the shape and direction of the radiation beam. It's possible, Dr Spanos said, to curve a beam around a mass of healthy tissue and focus it on a cancerous mass underneath or behind it with minimal harm to the healthy tissue.

Aiding in this process is a new feature of the treatment equipment—multi-leaf columnators—that block or admit radiation beams depending on their configuration. The standard method of focusing radiation beams had included the casting of several “blocks” made of an alloy material that kept the beam from going where it wasn’t supposed to go.

The multi-leaf columnator consists of a series of computer-controlled interwoven leaves. Now when the treatment field needs to change, a technician doesn’t have to come into the treatment area, disturb the patient and reconfigure the blocks for the new angle or treatment area. All of that can be done via computer.

“This accomplishes two things,” Dr Spanos said. “It improves the accuracy of the treatment and it allows for more treatment fields or angles in a reasonable period of time. The more treatment fields you have converging on one tumor area—in most situations—the better your ability to get the radiation to the area that needs to be treated.”

Researchers are finding that in addition to cancer treatments, radiation therapy benefits patients with a growing number of noncancerous illnesses, including heterotopic bone formation, macular degeneration and, more recently, coronary artery blockages.

In collaboration with **Massoud Leesar, MD**, and the U of L cardiology department,

researchers are testing the effectiveness of radiation after balloon angioplasty to decrease the possibility of artery reblocking. Preliminary data suggests the radiation improves the long-term effectiveness of the angioplasty treatment.

The strength of the U of L program, Dr Spanos stressed, is that it combines the latest treatment equipment with experienced faculty physicians who have the training and background to use that equipment for the maximum benefit of patients.

*The Journal thanks **inside UofL** for information contained in capsules pertaining to the University of Louisville.*

APPLICATION FOR SCIENTIFIC EXHIBITS

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1999 Annual Meeting

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- Exhibit must be dismantled and removed by 8:00 PM, Wednesday, September 29, 1999.
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- Contributions to organized medicine (including membership in county society, attendance of county and state meetings, service on committees, leadership as an officer, etc.)
- Individual medical service
- Community health, education and civic betterment
- Medical research

The nominee may qualify on any one or all combinations of these points. Reasons for the nominations should be clearly stated.

The Kentucky Medical Association Award is presented to an outstanding lay person in Kentucky each year in honor of his or her outstanding accomplishments in the field of public health and/or medical care.

The Awards Committee will have the responsibility to choose recipients of the KMA Distinguished Service Award and the Kentucky Medical Association Award. Any county society or individual member may suggest nominees to the committee.

The awards are presented at the President's Luncheon during the annual meeting.

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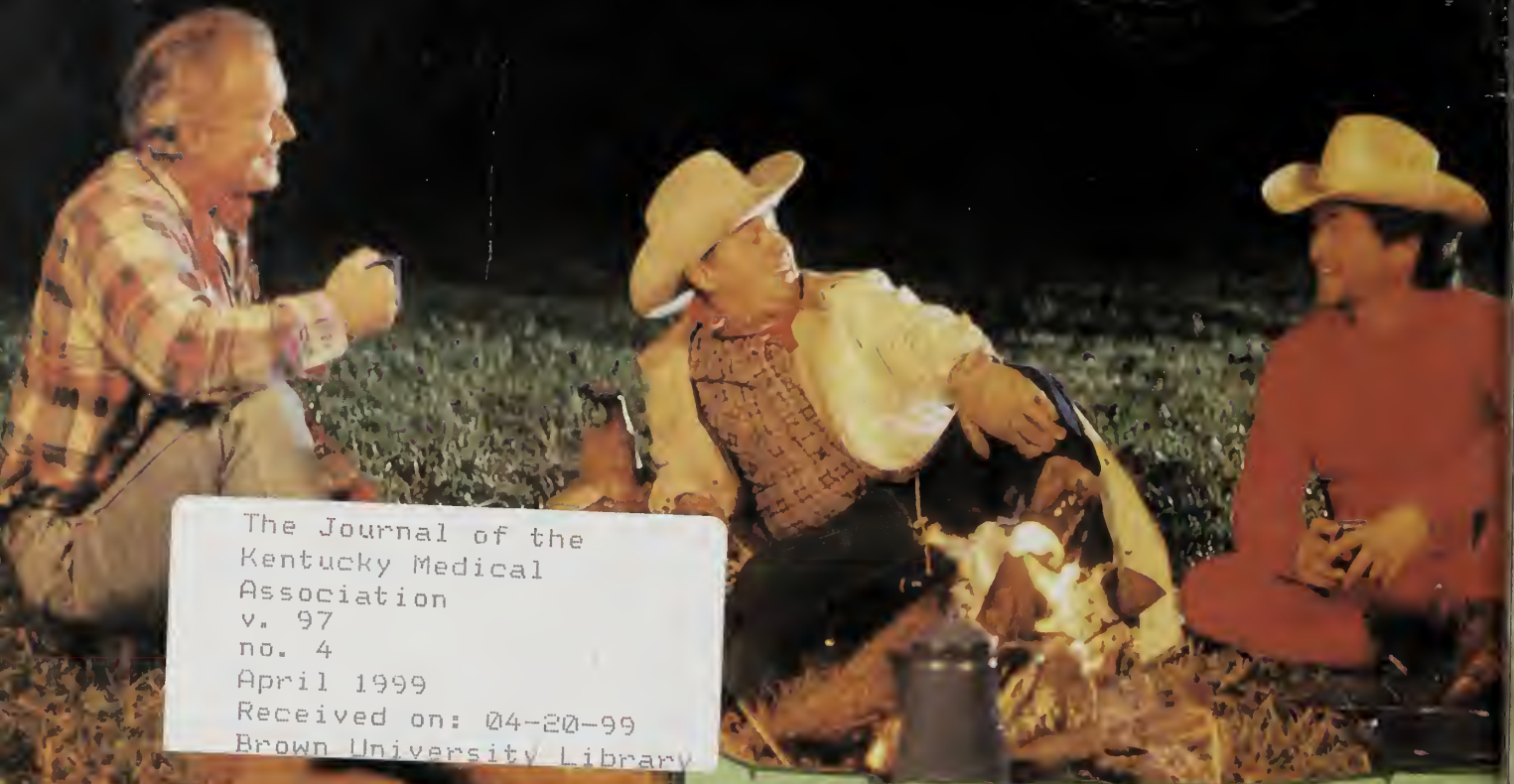
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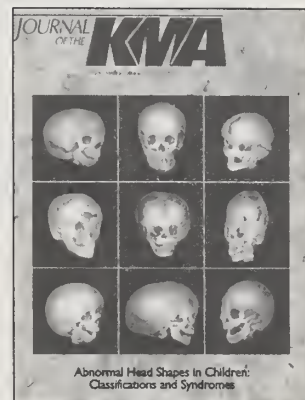
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COVER:

A UofL surgeon clarifies the various conditions responsible for abnormal head shapes in children. Clinical findings and treatment methods for these children will appear in the June 1999 issue.

Artwork by Lee Wade of Eminence, Kentucky.

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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Periodical postage paid at Louisville, KY and additional offices. Yearly subscription rates: \$35 domestic; \$45 foreign. Single issues \$4 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222. Telephone 502/426-6200. Fax 502/426-6877. Email member@kyma.org

Listed in *Index Medicus*. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

EDITORIAL AND ADVERTISING: Contact Sue Tharp, JKMA, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222. Phone 502/426-6200; FAX 502/426-6877.

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KMA ADDRESSES ONEROUS CONTRACT PROVISION



When a physician contracts with a health plan to provide services to members of the plan, the physician believes he or she must provide services only to members of the plan mentioned in the title of the contract. Many times, however, plans place provisions in a contract which require the physician to accept patients from other networks or plans the managed care company might have. By signing such an agreement, therefore, many physicians agree to accept patients from networks without realizing it. Such a contract provision is known as a "tie-in" provision or "all products" clause and is contained in some contracts used in Kentucky, including Aetna's. I have written Insurance Commissioner George Nichols requesting that action be taken to prohibit such contract provisions. That letter is set out below.

March 19, 1999

George Nichols
Commissioner of Insurance
Kentucky Department of Insurance
215 West Main Street
Frankfort, Kentucky 40601

Dear Commissioner Nichols:

You are aware of the disagreement between Aetna Insurance Company and many Kentucky physicians that serve Aetna patients. That disagreement centers on Aetna's insistence that participating physicians accept Aetna's "all or nothing" approach to contracting, which places physicians in an unfair advantage during the negotiation process. Aetna's practice of including an "all products" clause in its contracts with participating providers requires that they

serve as providers for enrollees of every health care product Aetna offers now or in the future. Such a provision causes patients in HMOs to lose access to their physicians of choice when physicians drop their Aetna affiliations due to disadvantageous contract requirements. I have enclosed a copy of Aetna's all-products clause for your review.

While Aetna and Kentucky's physician community may disagree on the effect an "all products" clause has on patient care, such a provision violates Kentucky's Unfair Trade Practices Act. As you may know, Nevada's Commissioner of Insurance recently declared "all products" clauses a violation of Nevada law (I have enclosed a copy of that opinion). Please note that the Nevada law cited—NRS 686A.090—parrots Kentucky's Unfair Trade Practices Act, specifically KRS 304.12-070. Since Aetna is licensed to conduct the business of insurance in this state, I am requesting you exercise your authority in this matter just as the Nevada Commissioner of Insurance did.

On a related matter, KMA hopes you will encourage the National Association of Insurance Commissioners, of which you are a respected leader, to convene a special working group to address the issue of the proposed Aetna-Prudential merger. Such a proposal was made by the American Medical

While the KMA believes in the right to contract, we oppose coercive tactics by large organizations that not only affect patient care, but violate Kentucky's insurance code.

Association in its January 4, 1999, letter to Honorable George M. Reider, Jr, President of the National Association of Insurance Commissioners. As you know, the AMA has taken an active role in pointing out the many problems with the proposed merger, many of which stem from continued difficulties physicians have had throughout the country. I have enclosed an article from *The New York Times* that discusses many of these problems, which are similar to the ones being encountered by Kentucky physicians.

While the KMA believes in the right to contract, we oppose coercive tactics by large organizations that not only affect patient care, but violate Kentucky's insurance code. I hope you will review this matter and if there is any additional information you may need, please do not hesitate to contact us.

Don R. Stephens, MD
KMA President

AETNA'S "ALL PRODUCTS" LANGUAGE

Company reserves the right to introduce new Plans during the course of this Agreement. Provider agrees that Provider will provide Covered Services to Members of such Plans under applicable compensation arrangements determined by the Company. Provider shall accept compensation in accordance with this Agreement for the provision of any Covered Services to Members under a Plan, regardless of whether Provider is a Participating Provider in such Plan. Company has or intends to seek a contract to serve Medicare and/or Medicaid beneficiaries. Such beneficiaries shall be considered as Members. Provider shall be bound by all requirements applicable to such contract and all rules and regulations of the Medicare and Medicaid programs.

MONITORING **Medicine**

NEWS FOR KENTUCKY PHYSICIANS

National Legislative Report Donald C. Barton, MD, Chair



Congress is in Session and the usual partisan and philosophical bickering is under way. Republicans are under pressure from Chambers of Commerce, managed care, and HMOs to minimize patient protection legislation. On the other hand, Democrats are demanding stringent patient protections or they threaten to turn the issue into a political football.

The AMA has established an Eight-Point Congressional Advocacy Agenda for 1999:

1. **Managed Care Reforms which include the following Patient Protection/Provider Fairness provisions:**

- **Defining Medical Necessity**—Medical Necessity should be determined only by physicians. This issue represents the crucial battle for physicians and patients. If managed care and HMOs win the battle to determine medical necessity, Independent External Appeal provisions and other patient protection/

provider mechanisms become meaningless.

- **External Appeals**—Patients should have the option of appealing adverse determinations, whether it is questions of medical necessity, or coverage limitations. Independent External Appeals Committees should be composed of licensed physicians of the same specialty being reviewed and physicians who practice in the same state where the patient is treated.
- **Accountability**—The ERISA provision granting immunity to HMOs and managed care bureaucrats should be repealed.
- **Prudent Lay Person Definition for Emergency Services.**
- **Prohibit Gag Practices/Clauses.**
- **Information Disclosure**—Require full disclosure of limitations, restrictions, and benefits, to patients, providers, and networks.

MONITORING **Medicine**

- Scope of Protection—
Federal protections should apply to all patients.
- 2. **Amend FTC laws to permit physicians to negotiate with health plans.**
- 3. **Fraud and Abuse Relief**
Refocus fraud and abuse to actual intended fraud and halt HCFA's practice of coercion by levying fines and penalties for inadvertent billing errors or mistakes.
- 4. **Regulatory Relief**
Reduce hassle factors by repealing voluminous regulations, amending Stark self-referral laws, and repealing portions of CLIA.
- 5. **Health Insurance Reforms**
Reform tax codes to transit health insurance from an employer based to individual based plans, and promote choices for patients.
- 6. **Medicare Reforms**
Seek long-term solvency in Medicare that promotes choice.
- 7. **New Knowledge for Clinical Practice**
Promote funding for research

that facilitates rapid introduction of medical innovations that improve care.

8. **Public Health**

Promote public health and safety measures.

Special antitrust protections for health insurers and managed care are primary targets. AMA's Quality Health Care Coalition Act would allow health professionals to negotiate collectively, level the playing field between managed care and physicians, permit individual physicians to bargain collectively with health plans, and be more effective patient care advocates.

The Presidents National Bipartisan Commission on Medicare failed to reach a consensus and has disbanded. The Commission failed to find middle ground or provide funding for prescription benefits, and proposals to gradually increase the age of eligibility.

AMA continues to struggle with HCFA over fraud and abuse. HCFA joined with AARP officials to establish a strike force to uncover fraud and abuse in

provider offices. President Nancy Dickey characterized the plan as one that makes elder citizens "Junior G-men." The campaign, while full of rhetoric, was short on facts. AMA noted that HCFA failed to document fraud, and in fact, the Office of the Inspector General could not document differences between fraud and billing errors.

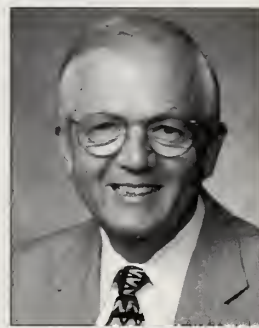
President Clinton has again proposed "User Fees" (provider tax) on providers to balance the budget. AMA has been the leader in opposing this unconscionable tax. Finally, the KMA has joined Associations throughout the nation opposing Administration plans to tax Association investment income.

Plans are underway to conduct a Washington visitation in May or June. During these strategically planned visits, KMA leadership meets individually with members of the Kentucky delegation. We urge every member to discuss these issues with their Congressmen and Senators.

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NEWS FOR KENTUCKY PHYSICIANS

State Legislative Committee Report Wally O. Montgomery, MD, Chair



The Committee on State Legislative Activities (COSLA) met on March 4. Our primary purpose was to establish a policy/guideline statement on health system reform. Secondly, the long-range plan directed COSLA to establish short- and long-term legislative priorities and strategies, and evaluate and prepare for future leadership and staff transition. Thirdly, the Committee considered several Resolutions and Board referrals. We concluded by discussing ongoing activities and preparing for the 2000 Kentucky General Assembly.

The following Resolutions were referred to the Committee:

- Resolution 98-112 directed the committee to produce an updated policy/guideline statement on Health System Reform.
 - Resolution 98-106 Credentialing of Nuclear Technologists.
 - Resolution 98-124 Physician Assistants.
 - Resolution 98-117 Gag clauses.
 - Resolution 98-111 Universal Access to Health Care.
 - Resolution 98-119—Insurance Department Enforcement of Late Payment Statutes.
 - Resolution 98-123—Universal Vaccine.
- Our second major responsibility was to implement portions of "Future Search," KMA's long-range plan. The Committee was assigned three goals:
- Pursue legislative goals as directed by the House of Delegates and develop and implement legislative strategies to achieve short- and long-term priorities.
 - Enhance and influence health care policy decisions in the governmental arena through strengthened regulatory oversight, by monitoring and improving relationships with appropriate administrative and legislative agencies.
 - Reevaluate and develop legislative priorities and strategies on an annual basis, and provide for continual transition of KMA leadership and staff.
- Thirdly, the Committee received reports from staff

MONITORING Medicine

regarding interim committee activities. Of special interest were regulations relating to House Bill 315, the Patient Protection package. Commissioner George Nichols and staff continue to meet with the various parties to implement HB 315. We are in negotiations with the Commissioner and managed care representation to implement an Independent External Review process. The most contentious issue in this process is defining "medical necessity." We believe only physicians can make that decision, and any reforms adopted fall short without appropriate definition of medical necessity.

Fayette County Medical Society President Michael Moore addressed the committee concerning the impact of Medicaid Managed Care upon the Fayette County Health Department. The 1998 Kentucky General Assembly adopted a budget, which assumed a \$187 million savings resulting from Medicaid managed care. The \$187 million savings was extracted from the Medicaid budget and distributed throughout the Commonwealth to fund so-called "state initiatives." Intervention by KMA is hampered by KMA policy. KMA House of Delegates policy clearly opposes delivery of primary health care in health department settings. In addition, we remain

opposed to further expansion of partnerships in other areas of the state unless and until the two pilot projects can clearly document success.

The Committee is recommending a change to House of Delegates Medicaid policy. Present policy opposes expansion of Medicaid unless and until present programs and providers are adequately funded. This policy somewhat "handcuffs" the Association in dealing with the Administration and the General Assembly. The Committee adopted the following recommendation, which allows some "wiggle room" but supports our historical position. *"The KMA recommends appropriate expansion of Medicaid to additional indigent patients provided the increased number of Medicaid eligible are properly funded by the Kentucky General Assembly."*

The Committee also discussed recent Supreme Court decisions relating to Confidentiality of Peer Review and the outlook for legislation that meets the "constitutional test." At this time legislation to get around the court's ruling is unlikely. We also reviewed KMA's position on Certificate of Need in light of changes proposed by the KHA. We have met with KHA on three occasions and

continue to reaffirm House of Delegate opposition to any effort to place physician offices under CON. The Legislative Task Force on Complementary and Alternative Therapy meets monthly. KMA will testify in May. KMA has just completed a survey of 2,100 primary care physicians and will present a summary of that survey. At this time, it appears the Task Force appears to support legislation authorizing the practice of "acupuncture."

The major issue of the 2000 General Assembly may revolve around the "tobacco settlement" money. A whopping 3.5 billion dollars "plus," over a 20-year period is at stake. Lots of hands are "reaching out" for the money. While the House of Delegates has not spoken directly to this issue, they have generally supported programs that assist tobacco farmers' transition to other crops. However, the major portion of Phase I money resulted from a suit over Medicaid. We would hope that a significant portion of Phase I money is used to fund and expand Medicaid and indigent care. In addition to the Phase I settlement, Governor Paul Patton negotiated with tobacco companies for an additional 5.15 billion dollars. This funding, referred to as Phase II, all goes to tobacco farmers and their communities. Stay tuned.

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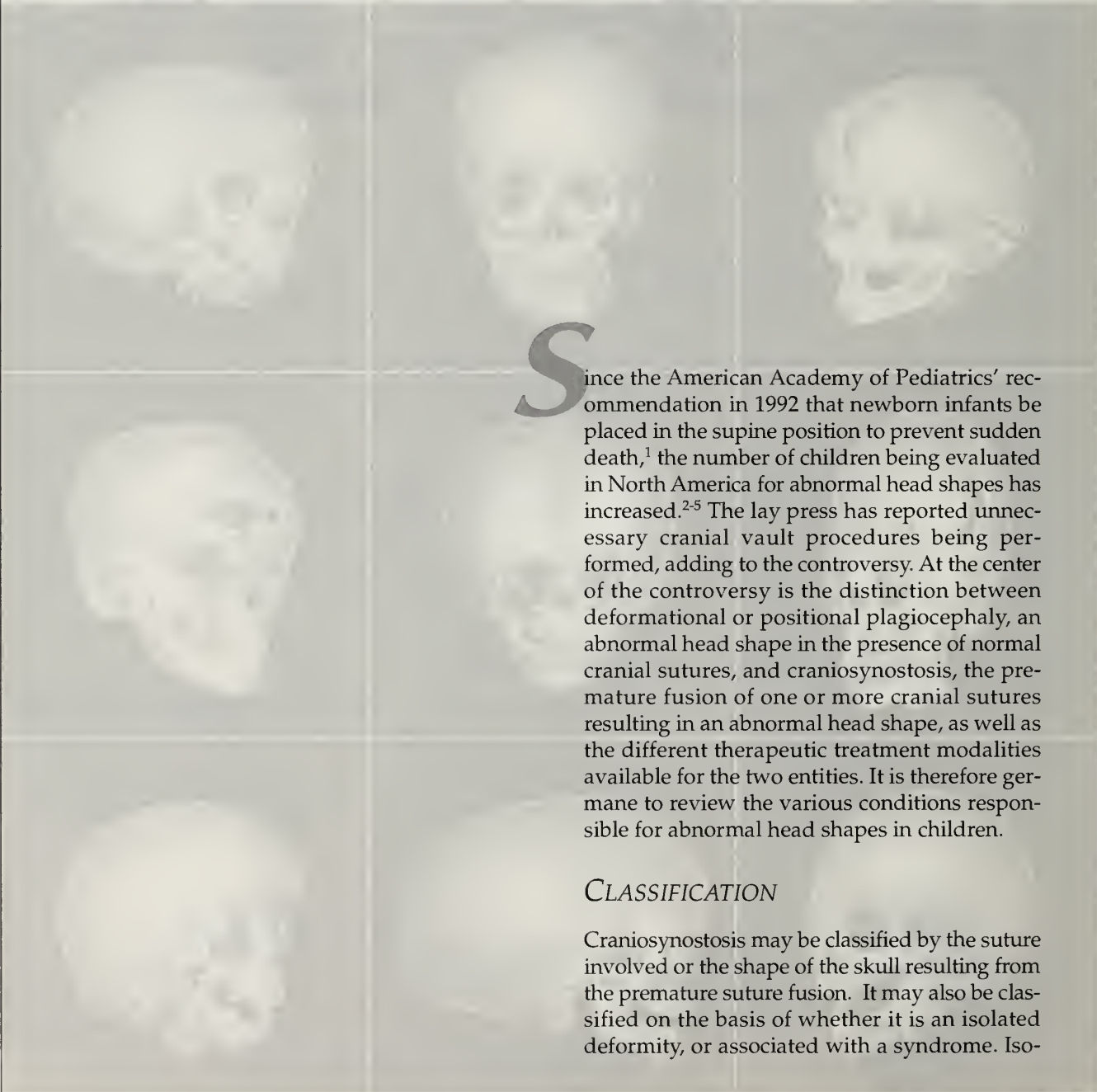
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ABNORMAL HEAD SHAPES IN CHILDREN: CLASSIFICATIONS AND SYNDROMES

Michael J. Sundine, MD



Since the American Academy of Pediatrics' recommendation in 1992 that newborn infants be placed in the supine position to prevent sudden death,¹ the number of children being evaluated in North America for abnormal head shapes has increased.²⁻⁵ The lay press has reported unnecessary cranial vault procedures being performed, adding to the controversy. At the center of the controversy is the distinction between deformational or positional plagiocephaly, an abnormal head shape in the presence of normal cranial sutures, and craniosynostosis, the premature fusion of one or more cranial sutures resulting in an abnormal head shape, as well as the different therapeutic treatment modalities available for the two entities. It is therefore germane to review the various conditions responsible for abnormal head shapes in children.

CLASSIFICATION

Craniosynostosis may be classified by the suture involved or the shape of the skull resulting from the premature suture fusion. It may also be classified on the basis of whether it is an isolated deformity, or associated with a syndrome. Iso-

lated craniosynostosis occurs with an incidence of approximately 0.4 per 1000. Craniosynostosis, alone, is not indicative of a single syndrome and may be associated with as many as 57 separate syndromes.⁶

Plagiocephaly, literally translated as "oblique skull," may affect either the anterior or posterior aspect of the calvarium depending on the skull surface affected. Unfortunately, in the medical literature, the term plagiocephaly has been used to describe abnormal head shapes in which there is craniosynostosis as well as when the sutures are unaffected. Much confusion surrounds the distinction between posterior plagiocephaly caused by lambdoid synostosis and deformational plagiocephaly.

Anterior plagiocephaly resulting from premature fusion of one of the coronal sutures results in a characteristic head shape. The forehead is flattened on the side of the involved suture with contralateral forehead bossing. The temporal area on the involved side may be bulging as well. The orbit on the involved side is constricted transversely and elongated vertically with elevation of the supraorbital rim compared to the contralateral side. Blunting of the superomedial orbit also occurs on the involved side. The nasal base is deviated to the involved side and the nasal tip diverges to the contralateral side. The ear is positioned in an anterior and superior direction relative to the opposite side⁷ (Figure 1).

In posterior plagiocephaly secondary to premature fusion of one of the lambdoid sutures, the occipital region on the affected side is flattened and positioned inferiorly relative to the opposite side. There is ipsilateral occipitomas-toid bossing and contralateral parietal bossing. The ear on the affected side is positioned posteriorly and inferiorly relative to the opposite side, and there may be contralateral frontal bossing. When viewed from above, the skull has a trapezoidal shape.⁸

Trigonocephaly, meaning triangular head, results from premature fusion of the metopic suture separating the frontal bones. There is a prominent midline forehead keel, and when viewed from above the skull appears to have a

triangular shape. There is a narrowed bitemporal distance, and there may be an associated hypotelorism (Figure 2).

Scaphocephaly is derived from the Greek word for boat-shaped skull caused by premature fusion of the sagittal suture. The resulting shape of the skull is elongated in the anterior-posterior direction, and there is bitemporal narrowing. There is associated bossing in the frontal and occipital areas. Of the isolated craniosynostoses, sagittal synostosis is believed to be the most common (Figures 3A and 3B).

Turricephaly means tall or tower skull, and *brachycephaly* means short skull. These deformities are found simultaneously in bicoronal synostosis, which may be isolated and non-

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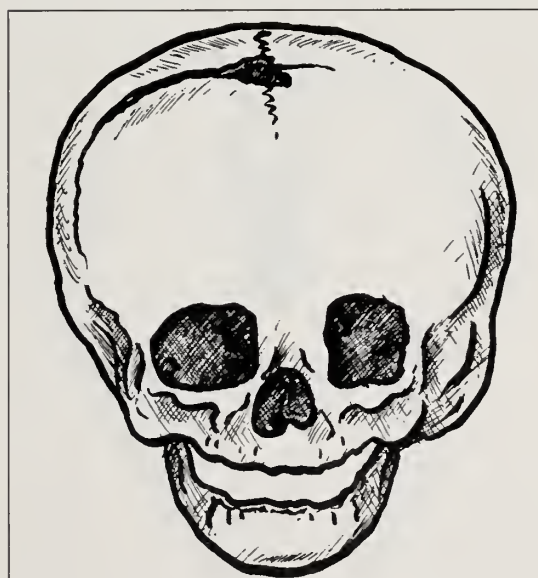


Figure 1. Anterior plagiocephaly. Skeletal changes seen in left coronal synostosis. The left coronal suture is closed. The left forehead is flattened with contralateral frontal bossing. The nasal root is deviated to the involved side. The involved orbit has increased vertical height and decreased transverse width. There is temporal bossing on the involved side.

ABNORMAL HEAD SHAPES IN CHILDREN (GRAND ROUNDS)

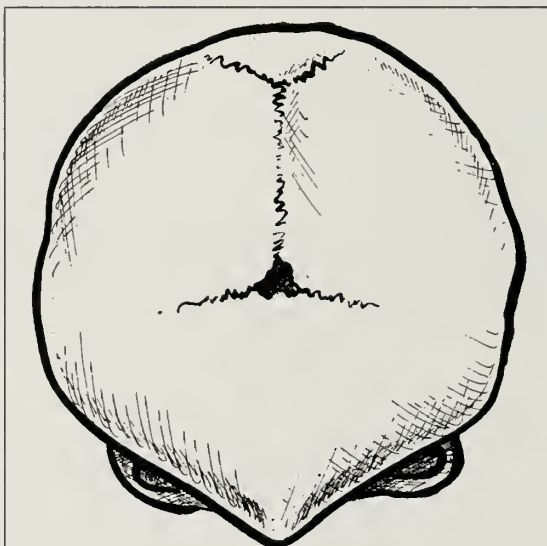


Figure 2. Trigonocephaly. Skeletal changes seen in metopic suture synostosis. The metopic suture is closed, and the characteristic triangular-shaped skull is demonstrated on the bird's eye view. There is a prominent midline keel and bitemporal narrowing. The associated hypotelorism is not demonstrated on this view.

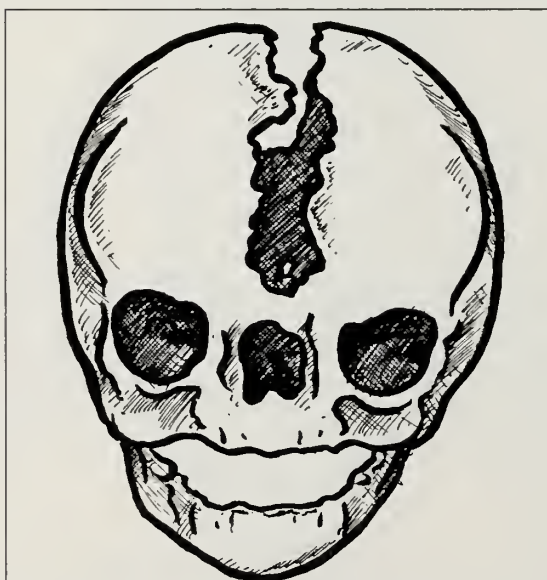
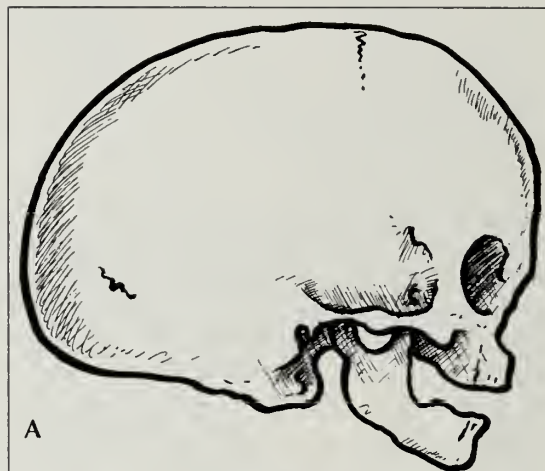


Figure 4. Turribrachycephaly. Skeletal changes seen in bicoronal synostosis. The skull is shortened in the anteroposterior direction and elongated in the superior-inferior direction. There is bitemporal bulging, and the coronal sutures are closed. There may be associated midfacial retrusion.



A



B

Figure 3. Scaphocephaly. Skeletal changes seen in sagittal suture synostosis. (A) The lateral view demonstrates the increased anteroposterior length of the skull and the classic boat-shaped skull. (B) The frontal view shows the decreased bitemporal width of the skull.

syndromal, or may be associated with one of the craniofacial dysostosis syndromes such as Apert or Crouzon. These patients' skulls are shortened in the anterior-posterior dimension, and there is bitemporal bulging. The skulls are vertically tall in the superior-inferior direction. The orbits may be shallow, and there may be exophthalmos (Figure 4).

Oxycephaly is translated to mean sharp or pointed skull. This unusual variant is generally seen in North African populations and involves multiple suture fusion.⁹

SYNDROMES

Craniosynostosis does not indicate the presence of a syndrome, but multiple syndromes often include it. The craniofacial dysostosis syndromes are familial disorders characterized by the presence of craniosynostosis and involvement of sutures of the cranial base.¹⁰ Features common to these syndromes are midfacial hypoplasia and craniosynostosis, which is most commonly manifest as bicoronal synostosis.

Apert syndrome, or acrocephalosyndactyly, occurs sporadically, although autosomal dominant transmission with complete penetrance has been reported. The incidence is estimated to be 1 per 100,000. It is characterized by bicoronal synostosis with turribrachycephaly, exorbitism, severe midfacial retrusion, and bilateral symmetrical syndactyly of the hands and feet, which typically involves the central digits. Other findings include acne vulgaris, a high arched palate, clefts of the hard and soft palates, dental crowding, and an anterior open bite. Apert syndrome is associated with some developmental delay, although there are no clear predictors for developmental delay.¹¹ The presence of the extremity syndactyly distinguishes Apert syndrome from other craniofacial dysostosis syndromes.⁶

Crouzon syndrome is also transmitted in an autosomal dominant fashion, and is characterized by almost complete penetrance. The incidence is reported to be 1 in 25,000. Crouzon defined the syndrome to have four characteristics: exorbitism (ocular proptosis due to shallow orbits); retromaxillism (midface retrusion); inframaxillism (anterior open bite); and paradoxical retrogenia. The calvarial appearance is usually one of turribrachycephaly due to bicoronal synostosis, but any pattern of suture fusion may occur.¹⁰

Pfeiffer syndrome is inherited in an autosomal dominant fashion with complete penetrance and variable expressivity. It is distinguished by

craniosynostosis, midfacial hypoplasia with exorbitism, and broad thumbs and toes.⁶

Saethre-Chotzen syndrome is an autosomal dominant disorder that includes craniosynostosis, a low hairline, upper eyelid ptosis, brachydactyly, and partial cutaneous syndactyly. It is also inherited, with complete penetrance and variable expressivity.⁶

Carpenter syndrome is unique in the craniofacial dysostosis syndromes because it is the only one transmitted by autosomal recessive inheritance. It consists of craniosynostosis, preaxial polydactyly, brachydactyly, clinodactyly, short stature, and obesity.⁶

Kleeblattschädel anomaly is the most severe of the craniofacial dysostosis syndromes, and fortunately, one of the least common. Inheritance is sporadic. The deformity may involve any combination of sutures of the calvarium, skull base, and face. The most common combination includes bilateral coronal synostosis and bilateral lambdoid synostosis, along with involvement of cranial base sutures. The growth restriction at these involved sutures combined with compensatory bulging through the open sagittal, metopic, and squamosal sutures leads to the classic cloverleaf skull appearance. These patients frequently have hydrocephalus. There is severe midface deficiency with exorbitism and hypertelorism. In addition, patients have stenosed nasal passages and may develop respiratory distress. Early tracheostomy and gastrostomy are required.⁶

Deformational Plagiocephaly Versus Craniosynostosis

Head shapes associated with metopic synostosis, sagittal synostosis, and those associated with the craniofacial dysostosis syndromes are distinctive and not difficult to diagnose. There has been some confusion, however, distinguishing positional or deformational plagiocephaly versus plagiocephaly resulting from craniosynostosis. Even recent reports in the craniofacial literature have demonstrated cases of so-called lambdoid synostosis which were, in fact, deformational plagiocephaly. The distinction between the two conditions is impor-

ABNORMAL HEAD SHAPES IN CHILDREN (GRAND ROUNDS)

Table 1. Anterior plagiocephaly versus deformational plagiocephaly

	Synostotic	Deformational
Ipsilateral		
Forehead	Flat	Flat
Superior orbital rim	Up	Down
Ear	Anterosuperior	Posteroinferior
Malar eminence	Anterior	Posterior
Palpebral fissure	Round	Slitlike
Nasal root	Toward ipsilateral	Midline
Chin point	Toward contralateral	Toward ipsilateral

Reprinted with permission from Bruneteau RJ, Mulliken JB. Frontal plagiocephaly: synostotic, compensational or deformational. *Plast Reconstr Surg.* 1992;89:21-31.

tant, since deformational plagiocephaly rarely requires operation, and plagiocephaly caused by craniosynostosis generally requires surgery.

In 1992, Bruneteau and Mulliken⁷ differentiated between *deformational plagiocephaly*, or the presence of an abnormal head shape due to extrinsic forces acting on the skull, and *synostotic plagiocephaly*, or the development of an abnormal head shape due to intrinsic cranial suture pathology. They characterized various facial structures relative to the flattened side in patients with the two conditions, and focused their attention to the anterior aspect of the skull

(Table 1). Interestingly, the findings in deformational plagiocephaly were opposite those of synostotic plagiocephaly relative to the side of the flattened forehead.

Huang et al⁸ characterized the difference between deformational or positional posterior plagiocephaly, and lambdoid synostosis and defined the differences relative to the flattened side (Table 2). The key findings are the presence of a parallelogram-shaped head (when observed from above) with the ear pushed forward on the side of the flattened occiput in deformational plagiocephaly, and a trapezoidal-shaped head, when observed from above, with the ear positioned posteriorly towards the stenotic suture.

The causes of positional plagiocephaly include intrauterine positioning, restrictive uterine environment, premature birth, birth trauma, sleeping position, torticollis, cervical spine abnormalities, lack of bone mineralization, neurological factors, or a multifactorial etiology.¹²

PATHOPHYSIOLOGY

Two fundamental issues regarding the development of abnormal head shapes in patients with craniosynostosis are brain growth in the

Table 2. Posterior plagiocephaly versus deformational plagiocephaly

Characteristic	Lambdoid Synostosis	Posterior Deformational Plagiocephaly
Contralateral posterior bossing	Parietal	Occipital
Frontal bossing	Contralateral	Ipsilateral
Ipsilateral occipitomastoid bossing	Present	Absent
Ipsilateral ear displacement	Posterior and inferior	Anterior
Skull base and face	Ipsilateral inferior tilt	Not tilted
Ridging of lambdoid suture	Present	Absent
Head shape: vertex view	Trapezoid	Parallelogram
Head shape: posterior view	Parallelogram	Normal
Lambdoid suture	Bony fusion	No fusion or fibrous union

Reprinted with permission from Huang MHS, et al. The differential diagnosis of posterior plagiocephaly: true lambdoid synostosis vs. positional molding. *Plast Reconstr Surg.* 1996;98:765-774.

child, and the presence of localized areas of growth restriction of the skull.

After birth, a child's brain undergoes a period of rapid growth for the first 6 to 7 years. The volume of the brain at birth averages approximately 330 mL; by age 2, its average volume is 900 mL.¹³ This rapid growth continues up to ages 5 to 7 when it is nearly 80% to 90% complete.

A child's skull grows in response to brain growth. The cranial sutures function as a joint between the bones of the calvarium, and as sites for skull growth and bone formation. The sutures are spread apart by growth of the brain, and new bone is laid down at the suture margins. Normal skull growth is perpendicular to the direction of a suture. In this manner, the rapid growth of the brain can be matched by growth of the skull. Subsequent changes are then obtained by remodeling growth after the sutures have closed.

In craniosynostosis, there is growth restriction at the stenosed suture, along with continued brain growth. Virchow¹⁴ noted that in the presence of a stenosed suture, compensatory growth of the skull continues parallel to the direction of the suture. Although Virchow's law does not entirely explain the changes noted in craniosynostosis, as noted by Delashaw et al,¹⁵ it provides a useful starting point to understand the deformity in a skull with stenosed sutures.

Editor's note: Clinical findings and treatment methods of abnormal head shapes will appear in the June 1999 issue.

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MULTIPLE SPONTANEOUSLY OCCURRING CORONARY ARTERY-LEFT VENTRICULAR COMMUNICATIONS: A CASE REPORT

Jay I. Lipoff, MD, FACC, FCCP

A search of the literature revealed that spontaneous coronary artery-left ventricular communications have only rarely been reported. These fistulae are frequently associated with angina pectoris which has been attributed to a ventricular steal phenomenon. The patient described herein presented with angina pectoris and was found to have multiple coronary arterioventricular communications without significant coronary atherosclerosis.

Case Report

A.W., a 54-year-old white male, was transferred to Marymount Medical Center from Hyden, Kentucky because of chest pain consistent with angina pectoris. Electrocardiogram demonstrated normal sinus rhythm, left anterior hemiblock, and pathological Q waves in lead V2 consistent with anteroseptal myocardial infarction, age undetermined. There were no ST segment or T wave abnormalities. Creatine kinase measurements including myocardial derived creatine kinase (MB-CK), and Troponin I were all negative for acute myocardial infarction. An anteroposterior (AP) chest radiograph was normal. Risk factors for coronary artery disease included a history of hypertension and cigarette smoking. On September 11, 1997, because of apparent post infarction angina, he underwent percutaneous transfemoral left heart catheterization including left ventriculography and bilateral selective coronary angiography. Left ventriculography in the 40 degree right anterior oblique

(RAO) projection demonstrated normal segmental wall motion without apparent chamber enlargement or mitral regurgitation. Left and right coronary angiography demonstrated right dominant anatomy and highly tortuous coronary arteries but no significant coronary atherosclerosis. However, each and every left or right coronary arteriogram produced prompt appearance of radiographic contrast material in the left ventricular cavity, ie, a left ventriculogram. Examination of the coronary arteriograms demonstrated that all perforating branches of the left anterior descending coronary artery and right posterior descending coronary artery empty directly into the left ventricular cavity (Figures 1 & 2). The patient declined further work up of his chest pain.

DISCUSSION

Fistulas emptying into the left ventricular cavity constitute only 3% of all coronary arterial fistulas, of which greater than 90% empty into the right heart or pulmonary artery.¹

The presence of direct communications between the coronary arteries and the cardiac chambers was first reported by Eie and Hillestad.² Duckworth reported a total of 13 cases in his review of this rare anomaly in 1987.³

Subsequently, other authors have described small numbers of cases.⁴⁻⁶ The largest series was reported by Elian et al who found 14 cases in 5,500 consecutive coronary arte-

1. MB-CK: Myocardial derived creatine kinase
2. AP: Anteroposterior
3. RAO: Right Anterior Oblique
4. LAD: Left anterior descending



Figure 1.



Figure 2.

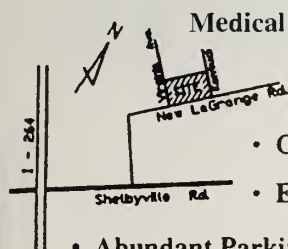
riograms.⁷ These authors report a preponderance of cases (12 vs 2) in which arterioventricular communications originate from the left anterior descending coronary artery alone as opposed to both the left anterior descending (LAD) and the right coronary artery. Each of their 14 patients had angina pectoris. Ahmed et al have described one patient with LAD coronary artery to left ventricle communication with typical exertional angina pectoris, no coronary atherosclerosis, and a stress thallium perfusion defect in the posterior wall of the left ventricle at maximal exercise which persisted for 5.5 hours.⁸ Marshall et al described a 61-year-old male with deep symmetrical T wave inversion during chest pain which was relieved by sublingual nitroglycerin and accompanied by a reversion to non-specific T wave abnormality. This patient was found to have a diffuse communication between the distal left circumflex coronary artery and the left ventricle. Despite the absence of significant coronary atherosclerosis or myocardial bridging, ultrafast computed tomography demonstrated non-uniform myocardial blood flow with marked hyperemia in the left circumflex distribution.⁴ This evidence certainly suggests that the chest pain is ischemic in etiology. It has been suggested by several authors that the angina and ischemia result from ventricular-coronary steal, but this remains unproven.^{3,4,7,8} The exact mechanism whereby this anomaly develops is unknown. However, it has been suggested that an abnormally prominent Thebesian system is involved. During normal embryonic development myocardial vessels arise from branches of the coronary arteries and veins as well as from endothelial protrusions into the intertrabecular

spaces. The outermost intertrabecular network becomes almost completely obliterated and forms a capillary network, whereas the innermost intertrabecular vessels retain their ventricular communications forming the Thebesian vessels of the adult heart.^{5,9} The reason for abnormal communication only with the left ventricle is unknown.⁹ Nevertheless, this very rare anatomic anomaly should be considered in the differential diagnosis of patients presenting with angina pectoris and evidence of myocardial ischemia.

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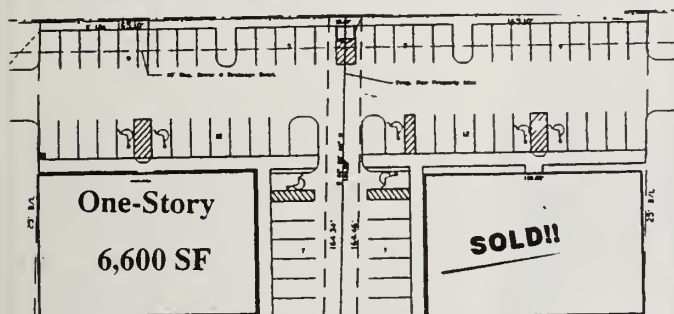
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Requirements include an MD or DO degree, board certification or eligibility (preference to certification) in an appropriate specialty such as Family Practice, Internal Medicine or Pediatrics. Must have a current Kentucky license or be eligible for Kentucky licensure prior to employment, must have a current DEA certificate, must have the ability and qualifications to meet all requirements for ambulatory care privileges for University Health Service.

The position will be available effective August 1, 1999. University of Kentucky offers benefits, including malpractice coverage, and participation in University Health Service Physician's Practice Plan.

To apply, please send your resume to: Job #SM16722, HR/Employment, 112 Scovell Hall, Lexington, KY 40506-0064, FAX (606) 257-1736 or come to our office to complete an application. If you have credentials already on file with our office, you may nominate by calling the CATskills Connection at (606) 257-3841 or by visiting our website and following the prompts. All responses must indicate the specific job number listed. Deadline for receipt of credentials/nomination is May 30, 1999, but may be extended if additional candidates are needed.



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ARDIS D. HOVEN, MD AMA COUNCIL ON MEDICAL SERVICE

Four KMA members serve in elected leadership roles in the American Medical Association. For a relatively small delegation of five Delegates and five Alternate Delegates, that is a significant accomplishment.

To inform you, our members, on what is taking place on your behalf at the AMA, the Journal is publishing interviews about the involvement, thoughts, and observations of these four leaders—"The AMA Connection."

This month we profile Ardis D. Hoven, MD, a member of the Council on Medical Service. This series began in the April Journal with a profile of Robert R. Goodin, MD, Member, AMA Council on Medical Education, and will continue in subsequent issues with profiles of William B. Monnig, MD, Secretary, Governing Council, Organized Medical Staff Section; and Bruce A. Scott, MD, Member, Board of Trustees, Young Physicians Designated Position.



JKMA: What is the mission of the KMA Council on Medical Service?

Dr Hoven: The overall responsibility of the Council on Medical Service is to be aware of and to stay informed on all issues related to access to health care; those issues that impact on the quality of health care; and to consider long-term strategic plans for making health care available to all individuals.

Right now, the Council is studying access to health care for the uninsured. We're reviewing one concept of insurance market reform that encourages individual ownership of health insurance through tax incen-

tives and is related to tax credits. We will be studying and planning individually selected, purchased and owned health insurance coverage. All of these issues address increasing access to health care for all individuals in this country, which has been one of the main concerns of the entire House of Delegates at the AMA for many, many years.

JKMA: What other current issues are you dealing with?

Dr Hoven: There are many issues at multiple levels. The Council deals generally with all reimbursement issues—Medicare and Medicaid payment review issues, etc. For example, we are currently dealing with the appropriateness of payment level differences by place and type of service. This is an ongoing issue the AMA is concerned with.

In these discussions, for example, we are very focused on maintenance of the patient/physician relationship in a positive way. I think that the factors which HCFA and the federal government have attempted to institute will actively interfere with this. One of the areas that the Council continues to monitor is the Medicare Integrity Program, specifically the PSRO Sixth Scope of Work and Post Payment Audit Reviews. My having been on the Practicing Physicians Advisory Council has given me an insight that a lot of physicians don't have into what actually can take place and what HCFA does try to do.

This is an extremely active council made up of superb individuals who have good minds and who are very willing to confront these issues. We will continue to observe the whole issue of access for the uninsured and individual insurance market reform.

JKMA: How do these issues and efforts affect or have impact on members, the practice of medicine, and the overall profession?

Dr Hoven: Clearly the first issue for members is that the council serves as a major voice for physicians and reflects the feeling of the members of the House of Delegates, because we constantly communicate with the various members of the House as individuals. Many of the resolutions that come out of the House

come to the Council for our review and evaluation and may be the subject of subsequent reports. We serve as a very important voice, and we serve as a voice at the national level.

Before my service began, I did not realize how important this Council's work is; its relationship to the Legislative body, to Congress, and with our various AMA representatives in Washington. Nor did I realize the interaction we were going to have with our legislative people from the AMA and the very important feedback they provide. For example, we get very specific reports from HCFA that contain concise and valuable information.

Not only do we serve as a voice for the House, but also as a reflective voice to report on what the members wish to know more about. It is important for the practice of medicine that we are able to maintain the patient/doctor relationship and to prevent, if possible, what HCFA, the Federal government, and other agencies may do to interfere with that relationship. Much of these efforts are reflected in what Congress passes through the Balanced Budget Act.

What are the real implications for the practice of medicine? I think that is fairly obvious. The survival of the patient/physician relationship is very important, and we must protect it. That is what we are all about.

JKMA: *What is your major goal as a member of the Council on Medical Service?*

Dr Hoven: When Don Barton suggested that I run for this Council, I thought he needed his head examined, because I didn't think there



was any way under heaven that (a) I would ever get elected, or (b) ever be able to do the work.

But I did run, and I am working. I serve as a voice to represent the patients and physicians in the state of Kentucky. I serve as a voice that has had experience in organized medicine. I serve as a representative of the state medical association. I also have had the opportunity of participation at the national level in an advisory council, which taught me a lot about how government works and why legislation appears as it does. As a member of that Council, what I want to see is many of the objectives that have already been set be determined and move on in a more progressive way.

I wish to add that I attribute much of my success in leadership to those who have preceded me. I think we in Kentucky have had extraordinary leadership from Don Barton, Wally Montgomery, and many people who have provided knowledge, understanding and patience to some of us. And lent us their wisdom in the process of trying to make change.

JKMA: *How are issues this Council deals with and their priorities determined?*

Dr Hoven: Members annually sit down for a "blue sky" round table discussion. That is where we elucidate all of the elements, issues, and items that we would like to see brought up for potential reports, discussions, learning activities, and so forth. Then we rank them according to their importance, by a weighted system.

We all have different focus areas. Some members are concerned with issues related to confidentiality; others have issues related to children. My particular area and concern, and the part I really love the most, is legislation and health policy. Making those two fit and work correctly, while at the same time protecting the rights of patients and physicians in the health care community is of great interest to me.

JKMA: *What is the greatest strength of the Council on Medical Service?*

Dr Hoven: The Council is made up of individuals who are willing to think broadly, to say, "this isn't

acceptable, we need to look for an alternative. No one else has seemingly been able to come up with that alternative; let us begin to put our minds together and see what we can do." The concept that the House supported about individually selected purchase of health insurance coverage has moved the concept of insuring people into another level. This is beginning to attract attention at the national legislative level. At some point coverage option may become law, thanks to the innovation of people who think outside the box, if you will, and who do not hesitate to look at new ideas and new concepts.

I believe this is one of the strongest Councils in the AMA. It is clearly one of the most challenging. For me, it is particularly important as it allows an understanding of legislation; it helps us to understand how laws can be made in a better way. We have been empowered and will continue to be more empowered to interact with the federal government and agencies to bring some good of all of this. We do have this diverse group of people with incredible backgrounds in health care delivery and a lot of knowledge and enthusiasm, which is exactly what it takes. These are the biggest and most important strengths, not only of the Council, but also of the AMA.

JKMA: *What area of this council needs more effort?*

Dr Hoven: In giving this serious thought, I couldn't identify one. There are so many items on the table to deal with. Probably, more time is what we need rather than more effort. The attendance rate is excellent, the participation is excel-

lent, our staff people at the AMA level are superb, and they've done an incredible job of accomplishing what needs to be accomplished. We continually need input from our colleagues throughout the federa-



tion of medicine to tell us what they are interested in; and they are not shy, so I don't think there will be a problem in their letting us know.

JKMA: *AMA membership in Kentucky continues to be stable, although AMA membership has been declining over the past few years, nationally. Why, in your opinion, should physicians support the AMA?*

Dr Hoven: The age-old question is "Why should physicians support the AMA?" AMA is one of our strongest advocacy voices. If you have never been to a Leadership Conference; if you've never been in Washington with AMA representatives; if you have never participated in a lot of these things and you just believe what other people tell you, you really don't have a sense of what is going on. If

all physicians really listened, they would know how strong that advocacy voice is, and without a doubt, during the past couple years that advocacy voice has gotten stronger. For example, most recently the AMA's definition of "medical necessity" is now going to be utilized at the national level for all government programs. That's AMA's doing—because physicians said "no, medical necessity is 'this,' not 'that.'" That's a classic example of what organized medicine at the national level has been able to do. I feel very strongly that if you visit with any of our representatives in Washington, members of the Board of Trustees, members of the Councils who do work in Washington, or in particular the extraordinary AMA staff, you will appreciate how effective the AMA has been. You will understand how knowledgeable these individuals are. These teams are made up of attorneys and accountants and PhDs in economics. The wealth of ability is extraordinary. I learn from them every time I have a chance to meet with them or hear them speak.

This is something we in Kentucky should relate to our colleagues who are not members of the AMA. One of the questions that our colleagues keep asking is "What's in it for me? I don't get enough out of my dollar." As I alluded to earlier, they are just not aware of how much value they are getting. If these things weren't being accomplished, I think they would really be screaming. Too much is taken for granted, and many physicians become very *passive* about their responsibility as an individual in organized medicine, and perhaps their responsibility to the patient/

doctor relationship and the practice environment itself. We should not always expect someone else to carry the load and make the decisions for us, rather than our being there and making these decisions ourselves. So, I'm not the one to talk to when you want me to pat you on the head and say, "Yeah, you're right, we don't give you the best for your dollar." Because that is not correct, and critics need to sit down and listen to what we have to say about the issues.

JKMA: *The AMA House of Delegates made some significant changes in the structure and governance of the AMA. Can you describe some of these changes and how they will affect the membership and the operation of AMA?*

Dr Hoven: In my eyes, a great strength of the AMA is the individuals that have expended incredible energy and intellect making this process work. The members of the House at the current time and those individuals who preceded us have pushed the envelope to say, "this isn't good enough, we can do better." The whole concept of restructuring and looking at some of the elements of the AMA is a reflection of that. The old system isn't working now. We need to make some changes.

And there continues to be change at multiple levels. We recognize that there will be issues—What is the function of the Board of Trustees? What should they be doing? They need to be "tending the shop," staying at home, working on fiduciary responsibilities, working on long-range planning elements, working with the House to guide medicine and with more oversight. These are concerns that

brought about changes over the past couple of years.

As a result of these changes, we expect to see more empowerment of physicians, and not just those physicians on the Board of Trustees. We will see more empowerment of physicians in the Councils and various other bodies that can speak for the House. We have such talent at that level that you can't give responsibilities to just two or three people. Perhaps the pyramid needs to be flattened out so there is no sharp peak at the top. Spread the work out and utilize people across the board who have taken the time and the energy to commit to the effort. That may be more appealing to physicians. Why spend the energy or the time if someone else is going to be delivering the



message, when perhaps your council or your committee chair or whomever is in just as good a position to speak. And it may be we need to empower more physicians in the AMA to get more of this work

done, because there is an incredible amount of work to be done.

JKMA: *What is the most critical issue facing the AMA? What should be done or is being done about it?*

Dr Hoven: Survival. We want the AMA to survive. How is it going to survive? Is it going to survive in a meaningful way? Or is it just going to be a "paper" group of people who pay dues and get reports periodically and read a newspaper periodically to find out about AMA activities. Or are they really going to be alive and performing in a meaningful way? The AMA worked well in years past, but my feeling is that, down the road, the way the AMA accomplishes its work will have to change. I think this is the message that the leadership in the AMA and the House is beginning to see and understand.

JKMA: *Patient Protection was the primary legislative goal of the AMA in 1998. While Congress failed to enact patient protection reforms in 1998, what is the outlook in 1999 and what other AMA legislative goals are we seeking in Washington?*

Dr Hoven: The Patient Protection law is going to be a major item. Heated debates made all the elements sound simple, but if you examine all the elements, you can understand how negotiations add or subtract, and change the intent to start with. We are going to have to spend a lot of time looking at Medicare; how Medicare, Parts A and B, are funded; are we going to get rid of A and B; are we going to keep A and B; what's going to happen with Medicare funding; how are Medicare patients going to be taken care of financially; are peo-

ple with some income over the age of 65 going to be paying more for their healthcare than they have been in the past; is that right or wrong? There are many, many issues here, but Medicare and its fiscal survival are at risk unless this is handled correctly.

More importantly, the survival of the patient/doctor relationship is going to be jeopardized if this is not done correctly. We have seen the whole issue of Medicare HMOs failing and HMOs pulling out of the Medicare program leaving people stranded. Where are they going to get their healthcare? What are the implications for the physician community, the hospital community, and so forth? That whole element is crucial to the survival of quality medical care in the future.

Then there are the HCFA issues; post payment audits, issues of provider taxes, fraud and abuse issues. I personally disdain the use of the term "fraud and abuse." I think every time we use this term we are buying into HCFA's mentality of guilt. Issues related to inadequate or improper billing, how do we handle those? So it is very important that these elements continue to be high on the agenda of the Council of Medical Services. HCFA issues, payment issues, Medicare issues are going to be very important elements in legislation coming up in the future in Washington.

JKMA: One final question. You've held numerous leadership positions at the state level with KMA, and for several years have been in that circle of

top leaders at the national level with AMA. How does KMA measure up from the standpoint of benefits to members, its leadership, etc?

Dr Hoven: Let me comment first that KMA provided me a superb template for understanding how organized medicine works. It began at a county level and worked up to the state level. I could see how to get something done, and to not be afraid to try to do something. You may step in a pile of mud periodically, but at least you are making an attempt at change. I learned the process. If you understand the process, then you can adapt to the AMA level and the national level. Yes, the elements are bigger, the number of people is bigger, but the template still exists. I thank KMA for giving me the opportunity to learn with that template. I think all of our leaders coming out of the state, now and in the future, will appreciate the template that has been provided for us.

KMA membership is extraordinary. We get a lot for our money. I don't think we have to apologize to anyone about KMA or its activities or what it has been able to accomplish in our own legislative body—at the local level, the county level, and all the way up. I think physicians probably don't pay enough attention to what goes on in their professional association. Many younger physicians have simply assumed that someone was going to take care of problems for them, because that is the way it has been done in years past. They are going to wake up one morning

and realize they are the ones supposedly taking care of the problems, and if they aren't active, then the house of medicine may be swept out from underneath them. That would be very painful.

I also think the individuals who preceded us—the Don Bartons, the Wally Montgomerys—had a sense of what organized medicine was really about, not only at the state level but also at the national level. People of their stature are the greatest strength of organized medicine—of the KMA and the AMA. Because they had the sense, the attitude, the knowledge to get the job done in their own way. They had the sense to understand what needed to be done and why it needed to be done.

Similarly, I feel a personal debt to former KMA Executive Vice President Bob Cox, as well as his successor Bill Applegate and many other individuals too numerous to mention, who brought leadership and vision to this Association and made all of this possible.

I am glad to be a part of organized medicine at this level. It is exciting and it's been one of the most challenging things I have ever done. I love it. It's a lot of work and meetings can get very long. But the time goes by very quickly, and I come away a stronger person, better member of the House, definitely a stronger member of the Council. I just hope I can keep up the work and do the job my colleagues have elected me to do.

Interview and photos by Sue Tharp, Managing Editor, JKMA.

COMMENTS AT A WHITE COAT CEREMONY

by Stuart Tobin, MD

Each year the University of Kentucky College of Medicine formally inducts first-year medical students into the school during a White Coat Ceremony. During this ceremony, students are presented with a white coat representing their chosen profession. In the company of their family, loved ones, student colleagues and faculty, students commit themselves to their chosen profession. At the 1998 ceremony, Dr Stuart Tobin, a Kentucky physician and UK Community-Based Faculty member, offered the following comments.

—Lois Margaret Nora, MD, JD
Associate Dean
Academic Affairs & Administration
UK College of Medicine

Because I've never given an address like this before, I sought advice from a friend, a retired circuit judge who has often spoken before large audiences. He made the following suggestions: "Stu, develop a brilliant opening; provide a concise, snappy conclusion; and make the distance between the two very short." I will try to follow his advice!

What is this career of medicine into which you are about to venture? To answer that question, I've composed a pie chart that I call The Generic Medical Pie. The five wedges are the following:

1. Scientific knowledge.
2. The art or practice of medicine.
3. The medical community:
others who espouse a similar

philosophy and perform the services of medical care in clinics, offices, and institutions; and the means of delivering that care.

4. Ethics: the set of guidelines that govern proper medical care and distinguish it from improper care.
5. Medical-spiritual humanism—or, better articulated, the constructive and destructive emotions and feelings that are made manifest when the other four wedges interact with one another.

Today, I will discuss that fifth wedge and one small but very important part of it—expressing compassion.

After 23 years of practicing medicine, what knowledge, insight, or modest wisdom can I impart to you so that you won't have to wait 23 years to discover it for yourselves? (Of course, because many of you are probably smarter than I, you will probably develop your own profound insights faster than I did, say, in 22 or 22.5 years rather than the 23 years it took me.)

I have discovered for myself the $E=MC^2$ of medicine, a truth that works again and again, that may not be exactly a law of physical medicine but is pretty close. So, those of you more than 35 years old, sharpen your pencils; those of you 30 to 35 years old, press the record button on your microcassette tape players; and those of you 20 to 29

years old, boot up your laptops and word processors. Here it is! Are you ready?

"If you do the right thing, the right thing will probably happen. If you do the wrong thing, the wrong thing will probably happen." That's it! Here's the beauty of it. You already know right from wrong, so you already have most of the answers. You will spend the next four years learning the technology, science, and art of medicine, and you will have ample opportunity to acquire medical knowledge. But that doesn't mean that you will implement that knowledge correctly.

Let's examine my earlier statement: "If you do the right thing, the right thing will probably happen." The operant word in this statement is *do*, not, *right*. Doing requires an act, a form of behavior. Most behavior is acquired. Therefore, it can be taught and ultimately learned. Having compassion is "doing the right thing."

When a patient comes in with complaints of burning and frequency upon urination, you as a physician will have to note the patient's symptoms and complaints, distill the objective findings, create a differential diagnosis, order appropriate laboratory tests, come to the correct diagnosis, and then initiate the proper treatment. All of this is learned or acquired behavior. Can you also learn to act thoughtfully, compassion-

ately, and caringly? Yes, I believe you can. Just as the prerequisite for acquiring technical knowledge is adequate brain power, the prerequisite for delivering compassionate, thoughtful care is the superego or conscience. The compassion already exists within you. What you need to learn is how to express it.

Doing the right thing doesn't guarantee a desired outcome with no complications or side effects. It does mean that you have empowered yourself with the knowledge that all that could have been done was done, and that you have honored yourself, your profession, and others who practice it. You are operating from the moral high ground, which, in a way, brings you a little closer to truth. Learned compassionate behavior should be practiced, just as you practice your other medical skills.

Your patients are smarter than you are. I don't mean that they have more scientific knowledge or know more about the art of medicine than you do. I do mean that they know whether you are compassionate and caring or not. They will read your body language and get messages you don't even know that you are sending. They know if you are not making eye contact. They know when you are distracted or irritable. They can tell whether your tone of voice is sincere or not. If you are sincere, they will know it. If you aren't, they will know that as well.

Tolerance and compassion are siblings. Many patients will embrace your personal philosophy, religious beliefs, socioeconomic values, ethical and

racial backgrounds, and identifying and dealing with these patients becomes easier. Many others will not. Take the opportunity to learn about different philosophies and attitudes, and learn to respect different points of view. Don't be judgmental.

Compassion comes in many different flavors. It doesn't originate from only one type of culture, religion, or doctrine. It's a human trait that exists in *all* cultures. If you want to express compassion, you should become familiar with its brother, tolerance. You must learn and practice both tolerance and compassion to make them work in concert. If you truly learn life's lesson of tolerance, you will find it easier to express compassion. So what is compassion?

Compassion means not taking yourself too seriously. Remember the old retort, "The cemetery is full of indispensable people." Remember that no one, at the time of death, ever said, "Gee, I wish I had spent more time at the office." In my waiting room I have a needlepoint banner that reads, "The Best Little Warhouse in Kentucky." My patients find it humorous. What that banner is attempting to say is that there is humor all around us; we just have to look for it. It will help you no matter what specialty you choose. It will make patients realize that you don't take yourself too seriously.

Compassion means meeting your patients' needs and expectations. Every patient who enters your office has expectations and will believe that you are a good physician if you address those expectations. Those expectations

usually concern diagnosis and treatment: "What's my diagnosis, and how are you going to cure my problem? Is it serious? I read about this in *Mademoiselle*, and my next-door neighbor had the same thing and was cured with . . . and I want the same thing." This scenario plays itself out regularly and frequently. You may think you are a physician, but in reality I often feel more like a waiter in a dermatology restaurant and the patient wants to order from the menu. So you think to yourself, "Well, this patient has acne. I was going to prescribe a topical antibiotic, but the patient wants Retin-A." And you think to yourself, "We can do that." So the patient has chosen a different entree from the dermatological menu, but it's still on the menu, so we can fill that order, even if it isn't the special of the day. If the patient orders something that isn't on the menu, well, "special orders do upset us." If a patient requests a treatment that doesn't fall within the bell-shaped curve of the standard of care, then you need to explain, in detail, why you can't honor that order. Don't worry whether you are a perfect waiter or not; they still won't leave you a tip.

Compassion means relieving your patients' anxiety. Every patient who enters my office has a high level of anxiety, which usually involves one or more of the following questions: "Do I have cancer? Is it going to kill me? Are you going to do some procedure that will hurt?" All of these thoughts produce an anxious state. I like to address these issues directly and to use humor to reduce the accompany-

ing anxiety. Before performing most surgical procedures, I take a photograph of the patient. When taking a close-up photo of a big toe, a right shoulder, or an ear, I always say to the patient, "Now give me a big smile!" This comment usually produces a small laugh. Then I offer the patient six wallet-sized copies and an 8" X 10" glossy, and this relaxes them even more. When patients articulate their anxiety about something going wrong during a procedure ("Well, Doc, what happens if you slip and cut my nose off or cut my throat?"), I tell them, "Get a lawyer. You won't even need a good one. Anyone will do." If they ask, "Doc, have you ever done this procedure before?" I quip, "The bad news is that I've never done it before, but the good news is that I only charge half price for things I haven't done before." Many patients notice my New York degrees or detect my non-Kentucky accent and ask, "Hey, Doc, how did you end up in Kentucky from New York City?" I respond, "It was the closest place to midtown Manhattan where I could find a parking spot." All of these scenarios have a positive effect by lessening the patient's anxiety through humor.

Compassion comes in small packages. What's a large package of compassion? "I saved your life." This doesn't happen very often in dermatology. Compassion for most patients comes in small packages, when we are sensitive to their medical needs. For example, when an elderly patient, dressed in her Sunday best, comes to your office, com-

pliment her. Acknowledgment goes a long way. "Well, Mrs Smith, that's a very pretty dress you're wearing, and that smile on your face makes it even prettier." One of my patients in her mid-80s once asked me, "Doctor, it takes me longer to vacuum my house than it did 50 years ago. Why is that?" I told her, "I don't know, but maybe you need a new vacuum cleaner." She smiled.

Compassion means being on the same level as your patient. Create a dialogue instead of a monologue. That means listening as well as talking. When all else fails, listen to your patients: they may be telling you something important. Compassion means that you recognize the following and share it with your patients: "Both of us are human beings, and, although I have some specialized knowledge and opinions that you are here to acquire, we're socially two equal human beings and I value you as such. That means that your time is just as valuable as mine, and if you had to wait longer than either of us wanted, I apologize. It wasn't by design. That means that if you have a question about your disease, I want to answer it. That means that if we don't get the desired results from your treatment, I will work with you to get things right." You know, patients can be compassionate, too.

Compassion means knowing yourself and your limitations. The sign of a good physician is not what he knows but what he will admit that he doesn't know. Patients find that an asset, not a liability, in physicians. Don't be afraid to say, "I don't know what

is wrong with you, but I care enough about you to send you to someone who might know." Patients aren't stupid. They know when they aren't getting better, and they wonder whether someone else might be able to help. If you use this approach, they will have more respect for you and will return to you again in the future for other medical problems.

Finally, have compassion for yourself. As you wander through medicine, you will be exposed to a great amount of stress. Some of you may have or may develop a temptation to relieve that stress with alcohol or drugs, which will certainly be more accessible to you. Some of you won't even need the stress to succumb to that temptation, and you already know who you are. Don't sail the Egyptian river—"Denial"—and fail to get help. You aren't bad people, but you will have made some bad decisions. Just as there are resources available to your patients for help, there are also resources available to you. Your colleagues will be there for you. Why? They will have compassion for you. Nothing will make a colleague drop everything faster to try to help you than when you say, "I'm having some really difficult problems and I need your help." The Impaired Physicians Program in Kentucky has helped many doctors with abuse problems return to successful and productive practices and lives.

In conclusion, as you develop into mature physicians, learn to express compassion for your patients, each other, and yourself.

Thank you. Congratulations, and the best of luck in your new white coats.

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Daniel W. Varga, MD

ON NURTURING

"We can understand a great deal of our history . . . by thinking of ourselves as conquerors and victims. In order to understand our own predicament and the work that is to be done, we would do well to shift the terms and say that we are divided between exploitation and nurture." So wrote Wendell Berry in *The Unsettling of America* as he described the dilemma of the small farmer in modern society. He might well have been referring to the state of medicine at the close of this millennium and the debate over patients' rights, physician autonomy, and the future structure of the health care delivery system. At the core of our current conflicts is a fundamental debate over the stewardship of the physician/patient relationship, the medical profession, and the public health. I believe that the ultimate resolution of this debate will depend greatly upon whom is seen as most capable of thoughtfully and compassionately nurturing these cornerstones of societal wellness.

At first glance, we physicians might innately view ourselves as the victims and nurturers in the aforementioned polarity, besieged at every turn by conquering and exploiting insurers, politicians, and regulators. Before adopting such a simplistic interpretation, however, we would do well to

examine Berry's further observations: "The terms exploitation and nurture . . . describe a division not only between persons but also within persons. We are all to some extent the products of an exploitive society, and it would be foolish and self-defeating to pretend that we do not bear its stamp." This insight challenges us as individual physicians and as a profession to an examination of conscience: to what degree do we exploit or nurture the vocation to which we have been called?

The fundamental principles of medicine call us as physicians to be nurturers. We toil from an early age to master a discipline that is both scientifically and humanistically exhaustive and exhausting. We are shepherded by mentors who impart their knowledge and experience to us without reservation and without proprietary consideration, just as they were nurtured by a preceding generation. The discipline we acquire, the discipline we continuously refine, becomes the sole tool we have to address the needs of our patients and our communities. We offer it selflessly and apply it evenhandedly, without attention to status, without expectation of notoriety. We nurture and support our colleagues as is befitting a profession. Our reward is a comfortable living, a still high

*This insight challenges us
as individual physicians
and as a profession to an
examination of conscience:
to what degree do we exploit
or nurture the vocation to
which we have been called?*

degree of respect among our fellow men, and the satisfaction of service to our communities.

How then do we confront the conflict that is intruding into our daily professional lives? Our patients and federal regulators suspect us of fraud and demand an accounting based on how much we write in a chart as opposed to how much we do. Insurers purport that they hold ultimate authority in the determination of medical necessity and disease management. We allow stark, economic based issues to define relationships between physician colleagues instead of professional consideration. We struggle daily with the need to balance the costs of care with our burgeoning technological capacity, the need to accommodate individual desires with societal concerns.

As Berry acknowledges, no one has a monopoly on nurturing

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to, if they are wise,
do the same.*

or exploitation. When we are challenged in regard to our altruism, we cannot summarily dismiss accusations with a merely presumed professional integrity. Our professional credibility must be real, active, and rigorous. When we are impugned as exploitive, we must answer with fact, and where we find ourselves, or are found by others, to be wanting, we must remedy our faults promptly and definitively. Wendell Berry notes that one question a nurturer asks about his land is "how much can be taken from it without

diminishing it" and that the standard against which he judges himself and his work is how well he cares for that which is entrusted to him. I believe that physicians and the medical profession do, and will continue to, ask themselves this question. I believe we do, and will continue to, judge ourselves by our stewardship. It will be for the other participants in the "health care industry" to, if they are wise, do the same.

Daniel Varga, MD



Carolyn Daley

Following is the Inaugural Address presented April 20, 1999, by Carolyn Daley, Hazard, as she assumed the presidency of the Kentucky Medical Association Alliance.

knowledge or skills that they need as a parent. Families need to form a caring, loving environment where there is respect for each family member. We must continue to communicate our care and concern for the health and welfare of all Kentuckians. We must be a voice for those who cannot speak for themselves. Each generation must help the next to become a literate and caring generation.

Research studies on how the brain develops show the crucial role of early language development. Early experiences, such as being read to, can enhance the architecture of a baby's brain. The American Academy of Pediatrics is now recommending that pediatricians prescribe reading to children from six months of age. There is more than a genetic component to the development of the IQ. Alliance members can help by encouraging reading to newborn babies, infants and young children. We can suggest to young parents activities and toys that will enhance the language development of their children. We can help to instill the love of learning which will last a lifetime. We can visit our schools, ask the teachers what they need and how we can help. We can volunteer to read to children in schools and in daycare centers.

We are pioneers into the next century, the next millennium. We must take with us our best, as we go forward together caring for each other and our neighbors . . . Let us go forth together, united in a common heritage and purpose, in service to all Kentuckians.

We can donate new and used books to school libraries, daycare centers, and to young families who do not have books in their home. We can help adults learn to read. We want every child in Kentucky to know that the KMA Alliance cares about them and their health. We want each child to have health education so that they will have the skills necessary to make healthy choices in life.

We are pioneers into the next century, the next millennium. We must take with us our best, as we go forward together caring for each other and our neighbors. Each KMA Alliance member has a role to play. What do you value? What is important to you? Pass that on to the next generation. With our mission defined, let us

KMA Alliance members have a 75-year history of caring and reaching out to our communities with a helping hand. We have extended our hands in friendship to physician spouses and families to help them when they are new to their communities or in time of need. We have promoted the health education of the children and the citizens of Kentucky. Most Alliance counties have established health-related scholarships. The KMAA has established endowed scholarships in the name of the KMA Alliance at the University of Louisville and the University of Kentucky Medical Schools. Alliance members are in a unique position to help our citizens. We are aware of health problems and the latest research toward solving health problems. We know the importance of reading to our children, of talking with our children, and of being there for them. Physician families are caring families. We must remember to care for ourselves and our families, then we can reach out to help those who do not have the

Our heritage of caring is the key to the success of the future generations of our KMA Alliance. Our friendship is our greatest strength. Please extend your hand in friendship and lend a helping hand to those in need.

go forward into the rest of 1999 and into the next millennium with hands outstretched in hospitality to help and to care. Our heritage of caring is the key to the success of the future generations of our KMA Alliance. Our friendship is our greatest strength. Please extend your hand in friendship and lend a helping hand to those in need.

One day I was visiting with a family in a hospital cafeteria. One lady said she had seen a notice that the health department was giving free flu shots. She said that she was going to get one because otherwise she could not afford it.

Later that evening, I asked Gil how much a flu shot costs. He said it probably cost about \$15. I will never forget that lady and her gratitude to the health department. I remember in grade school the health department nurses used to line up all the children and give us our immunization shots for the year. I remember the nurse saying, "This won't hurt a bit." Thank you to the health departments of Kentucky for your service to our citizens. Thank you to the Frontier Nursing Service and to the founder Mary Breckinridge who provided health care to all regions of Leslie County. I was born in the first hospital which was built under her instruction. Now there is a new hospital in Hyden and several physicians. The ARH Hospital in Hazard and other hospitals in Eastern Kentucky provide excellent care for the patients. There are about 80 physicians on staff at the Hazard ARH Hospital. We are grateful to all physicians and their families who serve in Kentucky. Thank you for our

heritage, for your dedication, and for your friendship.

The KMA Alliance, "serving Kentuckians for over 75 years," will in 1999-2000 promote literacy and reading to young children, promote a permanent health education program in our schools—Growing Healthy, promote the S.M.A.R.T (Students Made Aware Reject Tobacco) program in the schools, promote the SAVE (Stop America's Violence Everywhere) program, provide health-related articles to our newspapers, educate the public about organ donation, osteoporosis, and breast cancer, promote donations to medical schools through the AMA Foundation, have a voter registration drive, and will develop a homepage on the Internet.

Let us go forth together, united in a common heritage and purpose, in service to all Kentuckians.

Carolyn B. Daley
KMAA President

NEWSMAKERS

Wally O. Montgomery, MD, FACS, Paducah, recently received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at Western Baptist Hospital. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons.

Dr Montgomery, who has a significant interest in the diagnosis and treatment of patients with malignant diseases, provides leadership to the cancer committee at Western Baptist in order to maintain their Commission-approved cancer program. Dr Montgomery also provides community leadership by volunteering at the division or unit level of the American Cancer Society.

During March, in a salute to Women's History Month, Jefferson County announced a Hall of Fame recognizing achievements of local women. The first nine inductees, nearly all women acclaimed for being "firsts" in their fields, were honored at a ceremony at the courthouse. **Melinda G. Rowe, MD**, was recognized for her service since May 1995 as Jefferson County's first woman health director.

James G. O'Brien, MD, Louisville, was awarded 1998 Medical Director of the Year from the Kentucky Association of Health Care Facilities at their recent meeting in Lexington. Dr O'Brien was recognized for

his work as medical director for Christian Church Homes of Kentucky. He is the medical director of several other facilities and is the Margaret D. Smock Endowed Professor in Geriatrics at the Department of Family and Community Medicine, University of Louisville.

Gary S. Marshall, MD, University of Louisville Pediatrics Department, has been elected into the Society of Pediatric Research.

Louisville psychiatrist **Clifford Kuhn, MD**, recently administered a healthy dose of humor during the Community Health Leadership Awards Dinner presented by Community Health Charities. The organization recognized University of Louisville President John Shumaker and the University with its 1999 Community Health Leadership Award, citing the University's contributions in areas including research and educational support. Community Health Charities is a statewide federation of 23 publicly supported, nonprofit voluntary health agencies. The federation raises funds on behalf of its member agencies for medical research, public education, and patient support programs.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

BARREN

David German MD IM
1008 Glenview Dr Ste C
Glasgow KY 42141
1988 U of IL Peoria
Venkatesh Madadi MD AN
PO Box 1947
Glasgow KY 42142
1987 Osmania Med Col India
Muralidhar Santapuram MD AN
115 Robin Dr
Glasgow KY 42141-1452
1988 Osmania Med Col India

BOONE

Marc Connery MD PD
1120 Boone Aire Rd Ste A
Florence KY 41042
1994 U of IL Col of Med

BOYD

Laura Reed MD TS
2301 Lexington Ave Ste 125
Ashland KY 41101-2807
1988 Wayne St U Michigan

GREENUP

Angela Lewis DO FP
533 Sunset Dr
Ashland KY 41101
1995 W Virginia S of Osteopathic Med

HARDIN

William Smith MD D
914 N Dixie Hwy Ste 109
Elizabethtown KY 42701
1990 U of Louisville

JEFFERSON

Bruce Benninger MD OBG
6618 Moss Creek Pl
Indianapolis IN 46237
1991 Indiana U
Julia Brown MD FP
7612 Shepherdsville Rd
Louisville KY 40219-2963
1995 Northeastern Ohio U

Amy Deeley MD OBG
3991 Dutchmans Ln Suite 310
Louisville KY 40207-4700

1994 U of Kentucky
Timothy Heine MD AN
233 E Gray Ste 612
Louisville KY 40202
1988 U of Louisville

Anthony Martin MD GE
550 S Jackson St
Louisville KY 40292
1983 U of Louisville

Dennis Smith MD U
250 E Liberty St Ste 602
Louisville KY 40202-1576
1992 Case Western Reserve U

Jonathan Weeks MD OBG
902 Woodland Heights Dr
Louisville KY 40245
1984 U of Kentucky

Daniel Weintraub MD P
200 East Chestnut St
Louisville KY 40232-5070
1991 U of Maryland

JOHNSON

Kedarnath Joshi MD R
625 James S Trimble Blvd
Paintsville KY 41240
1967 BJ Med Col India

KENTON

Christopher Cunha MD PD
2865 Chancellor Dr Ste 225
Crestview Hills KY 41017
1985 U of Southern Florida

MCCRACKEN

Marius Maxwell MD NS
5154 Village Square Dr
Paducah KY 42001-9060
1985 U of Cambridge England

Sue Ellen Petty MD S
115 Spring Valley Cove
Paducah KY 42003
1993 U of Louisville

MORGAN

Vaqar Ali MD IM
540 Jetts Dr
Jackson KY 41339
1989 Rawalpindi Med Col
Pakistan

MUHLENBERG

Todd Stiles MD PTH
508 Hopkinsville St
Greenville KY 42345
1991 U of Tennessee

PIKE

Naveed Ahmed MD N
162 S Mayo Trl
Pikeville KY 41502
1982 Mysore Med Col India

Ravinder Bhagrath MD NEP
54 Keyser Hts
Pikeville KY 41501-1649
1985 U of Southampton England

Glenn Irwin MD EM
389 Penhook Heights
Harold KY 41635
1980 Pennsylvania St

William Kendall MD R
138 Cedar Creek
Lexington KY 41501
1994 U of Kentucky

David Martin MD FP
114 Hibbard Street
Pikeville KY 41501
1995 U of Louisville

Khaled Mohamed MD P
98 River Rd
Pikeville KY 41501
1983 Cairo U Egypt

WARREN

Diego Mastronardi MD FP
201 Park St
Bowling Green KY 42102-9007
1989 U of Ottawa Canada

IN-TRAINING

FAYETTE

Emily DeFranco DO OBG

JEFFERSON

David Antekeier MD ORS
Steven Goudy MD S
Tapan Padhya MD OTO
Angela Savatiel MD OBG
Yunus Muneer Shah MD AN
Alexandra Williams MD IM

OBITUARIES

Jesse B Bell, MD
Louisville, KY
1904-1998

Jesse Bell, MD, a retired family practitioner, died November 27, 1998. Dr Bell was a 1931 graduate of Meharry Medical College and was the first African American to serve on the University of Louisville Board of Overseers. In 1990, Dr Bell was inducted into the American Lung Association's Hall of Fame. He was a life member of KMA.

Richard Jackson, MD
Danville, KY
1915-1998

Richard Jackson, MD, a retired general surgeon, died December 28, 1998. Dr Jackson was a 1939 graduate of Cornell University School of Medicine and was a life member of KMA.

Hugh Mahaffrey, MD
Richmond, KY
1903-1999

Hugh Mahaffrey, MD, a retired general practitioner, died January

8, 1999. A 1928 graduate of the University of Louisville School of Medicine, Dr Mahaffrey was a life member of KMA.

Rosco Faulkner, MD
Salem, KY
1901-1999

Rosco Faulkner, MD, a retired general practitioner, died January 16, 1999. Dr Faulkner was a 1930 graduate of the University of Tennessee College of Medicine and a life member of KMA.

Robert B Nolan, MD
Louisville, KY
1921-1999

Robert Nolan, MD, a retired general practitioner, died February 4, 1999. A 1945 graduate of the University of Louisville School of Medicine, Dr Nolan was a life member of KMA.

Theodore J Goldbloom, MD
Corbin, KY
1933-1999

Theodore Goldbloom, MD, a retired psychiatrist, died March 2,

1999. Dr Goldbloom was a 1957 graduate of the University of British Columbia and was an active member of KMA.

Carl H Scott, MD
Lexington, KY
1923-1999

Carl H Scott, MD, a retired pediatrician, died March 18, 1999. A 1950 graduate of the University of Louisville School of Medicine, Dr Scott was a life member of KMA.



HEALTH CARE ALTERNATIVES

KMA Annual Meeting

Sept 27 - 30

Hyatt Regency/Lexington Center
Lexington, Kentucky

APPLICATION FOR SCIENTIFIC EXHIBITS

Kentucky Medical Association
1999 Annual Meeting

Lexington Center, Lexington, KY
September 27-29

1. Title of exhibit _____
2. Name(s) of exhibitor(s) _____
Address _____
Professional title _____
3. Institution if other than exhibitor _____
4. Amount of backwall footage required _____
(The draped booth has 4' side walls. This footage should not be included in backwall footage required). TABLE DESIRED? _____
(Table 2' deep x width of backwall (footage) ELECTRICAL OUTLET DESIRED? _____
5. Will summary printed matter be available or obtainable for the interested physician? _____
6. Indicate sources of assistance provided to you in connection with this exhibit _____
7. Has this exhibit been displayed before? If so, when & where? _____

8. It is required that you attach a rough sketch or photograph and a brief outline of your exhibit to include: (a) content of the presentation and (b) the method, eg, equipment to be used.

Date _____

Signature of Applicant

Fill out and mail to:
XXXXXXXXXXXXXXXXXXXX, Chairman
Scientific Exhibits Committee
Kentucky Medical Association
4965 US Hwy 42, Ste 2000
Louisville, KY 40222-6301

The Kentucky Medical Association welcomes and supports scientific exhibits as a facet of continuing postgraduate education.

**Applications for space should be received before
June 30, 1999.**

- **COMMERCIALISM**, such as utilizing the name of sponsoring organization or facility, either on the exhibit or in printed materials, is **PROHIBITED**.
- KMA provides, without cost to the exhibitor, one 2 ft. table, bracket lights and a title sign.
- Spotlights, view boxes, furniture, decorations, etc, may be furnished by the exhibitor or may be rented, if desired, by applying directly to the George E. Fern Company, 3752 Crittenden Dr, Louisville, Kentucky 40209.
- Transportation and erection costs are the responsibility of the exhibitor.
- Exhibit must be attended during intermissions to answer physicians' questions. It is also desirable to have someone in attendance throughout the program.
- Equipment which will create noise must not be used during the general sessions and, at other times, must be controlled by head or earphones or a muffling device.
- Exhibit must be dismantled and removed by 8:00 PM, Wednesday, September 29, 1999.
- Exhibit space is strictly limited to footage and space allotted. No exhibit may extend into the aisle.

Commonwealth Convention Center and the Kentucky Medical Association or its agents cannot guarantee against loss or damage and will assume no liability for damages nor guarantee the exhibitor against loss of any kind. The exhibitor agrees, with the Association, to be responsible to the Commonwealth Convention Center for damages that may occur as a result of the exhibitor's use of the facility.

KMA Legislative Goals Set for 2000 General Assembly

The KMA Committee on State Legislative Activities (COSLA) met recently to discuss 1998 House of Delegates actions and prepare for the 2000 Kentucky General Assembly. COSLA adopted an extensive 17-page document covering various facets of health system reform; reviewed Interim activities of the General Assembly and the KMA Legislative Department; and adopted several actions related to House of Delegate referrals.

The Committee adopted the following short- and long-term priorities for consideration by the Board of Trustees and House of Delegates:

- Tort Reform
- Patient protection/Provider Fairness
- Public health measures relating to health and safety
- Medical education and research
- Non-physician health care providers
- Development of an Independent External Review package
- Organ Donor legislation to permit "opt out" rather than "opting in"
- Parity for mental health benefits
- Delete Aids Education requirement for CME
- Enforcement of late payment statutes
- Implement the Universal Vaccine program in Kentucky

The Committee continues studying Confidentiality of Peer

Review and whether or not to re-enact legislation. In addition, discussion of the Certificate of Need law continues in meetings with the Kentucky Hospital Association.

Professional Courtesy—Does It Violate the Law?

The AMA is fighting the government to allow professional courtesy among physicians without it being a violation of federal law. Currently, federal law forbids physicians from giving anything in exchange for referrals, including professional courtesy. Under another rationale, "insurance-only" professional courtesy may constitute a "false claim."

Ad Hoc Committee on Cardiovascular Services

The Ad Hoc Committee on Cardiovascular Services has actively addressed the development of medical care delivery networks by insurance companies. Appointed by the Board to evaluate the Coronary Services Network being implemented by Anthem Blue Cross—Blue Shield, the Committee has already held two meetings. Additionally, Chair **Robert R. Goodin, MD**, and staff have met with representatives of the Kentucky Hospital Association, Anthem, and the Insurance Commissioner. The focal thrust of the Committee has been to assure that requirements for network operations meet

health care reform statute requirements. The Committee continues to work for a consensus on these issues.

New Medicare Requirement

The Health Care Financing Administration (HCFA), which manages the federal Medicare program, has imposed a new requirement on physicians and other health care providers. Effective April 1, 1999, physicians must provide Medicare beneficiaries with itemized billing statements when requested. This requirement is part of the government's new fraud & abuse initiative.

Medicare Audits Show Reduction in Improper Payments, Documentation Errors

According to the latest government audit, Medicare paid out \$12.6 billion in overpayments in 1998, which represents 7% of total Medicare payments. This amounts to a significant reduction in estimated overpayments from 1997, which amounted to \$20.3 billion.

The greatest reduction of improper payments occurred in documentation errors, which dropped significantly from \$9.0 billion in 1997 to \$2.1 billion in 1998. Errors due to the lack of medical necessity represented the highest error category for 1998.

The AMA and other organizations continue to question the validity of these

audits since they are based on a small sampling of claims. It is also important to note that the government concedes there is no way of knowing how much of the improper payments constitutes fraud. The entire report is on the HCFA OIG website (<http://www.hhs.gov/progorg/oas/cats/hcfa.html>).

KEMPAC Wins Three AMPAC Awards

AMPAC has honored KEMPAC with three achievement awards for its success in attaining its membership goals for 1998.

1st place—Goal Achievement
(only 7 states received this award)

2nd place—Total revenue by tier
(Based on medical society membership size)

3rd place—Greatest Percentage of Members to Potential
Charles L. Garrett, MD, AMPAC Board Member, will present the awards at the Annual KEMPAC Seminar scheduled this year for Monday, September 27, 1999, at the Hyatt Regency Hotel, Lexington.

AMA Resources Available for Y2K

The AMA has been very active in developing tools physicians can use in addressing this issue:

- **Preparing for the Year 2000**
Website (<http://www.ama-assn.org/not-mo/y2k/index.htm>). This is updated regularly and has links to related sites.

- **The Year 2000 Problem: Guidelines for Protecting Your Patient and Practice**
book. A 73-page publication contains a self-assessment and more than 20 practical tips for physicians. KMA members can download it from the KMA website (www.kyma.org). The book can be ordered from AMA Customer Service at 800/621.8335. \$25 for AMA members; \$100 for nonmembers.

Additional Companies Share Y2K Plans

In follow up to a request from KMA and other entities, we have now received responses on Y2K compliance plans from the following companies:

Anthem
CHA Health
CHC
Emerald Health
First Health
Health Star
Humana
MEDCO
MultiPlan
PacifiCare
PHCS
Preferred Health Plan
PRO-NET
United Health Group
Wellmark

KMA can provide copies of any of these plans for your records. A list of plans are updated regularly on the KMA website (www.kyma.org)

Senate Finds Health-Care Industry Unprepared for Y2K

A US Senate committee recently held hearings on the Y2K problem. The panel found that while many industries are frantically preparing for potential problems, the health care industry has done little to address the issue. According to one report, 64% of US hospitals have no plans to test for Y2K problems.

KMA Trustees to Visit Hospitals

In an effort to better understand members' needs and to brief them on Association activities, KMA Trustees will be traveling this year to provide a program at hospital medical staff meetings across the state. KMA can provide a planned 20-minute agenda, or a program can be tailored to meet your hospital's needs. Contact KMA or your Trustee if you would like to arrange a meeting at your hospital.

Breast Cancer Hits African-American Women Hardest, Say U of L Researchers

According to the findings of two University of Louisville medical school researchers, African-American women diagnosed with breast cancer are less likely to be cured and more likely to die—and to die sooner—than Caucasian or Asian-American women, even when their ages and disease states are comparable.

The University reports that **Michael J. Edwards, MD**, associate professor of surgery at U of L's James Graham Brown Cancer Center, and **John W. Gamel, MD**, professor of ophthalmology and visual sciences who created the statistical model for study, looked at the "survival mechanisms" available for women with breast cancer.

Genetic Makeup, Well-done Meats Increase Risk for Breast Cancer

National research shows women who eat well-done beef and bacon are four times more likely to get breast cancer. A University of Louisville study suggests the risk is even greater for women who are genetically predisposed to developing breast cancer and who eat well-done meat.

The study looked at women who have inherited enzymes that activate chemical carcinogens found in well-done meats. DNA samples and information on consumption of well-done meat were obtained from 154 breast cancer patients and 328 controls.

Pharmacologist David Hein said the team also is looking at hereditary genes that predispose women to breast cancer from cigarette smoke.

Bottled Water May Not be Best for Kids' Teeth

For years, tap water with fluoride has helped fight cavities among

children. Families who drink bottled or filtered water may be losing that benefit, says a University of Louisville researcher. Stephen Feldman of the U of L School of Dentistry says bottled or filtered water usually contains little, if any, fluoride. Other water products may have too much fluoride, which can result in permanently stained teeth. He suggests having water tested by the local health department to check the fluoride levels; dentists can provide supplements if the drinking water is found lacking.

Feldman thinks parents should be even more concerned with what their children eat, such as high-sugar junk foods, and with their children's brushing habits.

Total Laparoscopic Hysterectomy Performed

A University of Louisville obstetrician-gynecologist has performed what may be the area's first hysterectomies done entirely by laparoscopy.

Resad Pasic PhD, MD, an assistant professor in the medical school's obstetrics-gynecology department, said the procedure known as total laparoscopic hysterectomy (TLH) can be a vast improvement over the traditional surgery to remove all or part of the uterus.

"It's easier to see what you're doing with this approach," Dr Pasic said. "It affords the physician better control of bleeding during surgery, and patients are out of the hospital

within a day or two of the procedure. They can often return to work in 10 days to two weeks."

According to the University's report, the procedure involves inserting a needle through a centimeter-long incision in the navel and injecting gas into the abdominal cavity, creating an expanded space in which the physician can work, he said.

A lighted instrument attached to a camera is inserted through the navel incision. The physician watches the camera's image on a monitor and operates microscopically through three more small incisions made in the lower abdomen. Once blood vessels and connecting tissues have been detached, the doctor makes a small incision through the pelvic floor and removes the uterus through the vagina.

Dr Pasic said such microsurgical procedures are safer than the more traditional operations, and recovery is faster and less painful. Use of smaller incisions reduces the possibility of excessive blood loss and postsurgical infections, he said.

A procedure that detaches the upper part of the uterus laparoscopically and requires vaginal surgery to complete the removal has been increasing in use; however, many women have biological or anatomical conditions that preclude the procedure. The newer *total* laparoscopic procedure offers minimally invasive surgeries such as this one to a much broader range of patients, Dr Pasic said.

AWARDS NOMINATIONS

The KMA Awards Committee is accepting nominations for the two highest awards the Association presents. The Distinguished Service Award is presented annually to a member of the Association based on the following criteria:

- Contributions to organized medicine (including membership in county society, attendance of county and state meetings, service on committees, leadership as an officer, etc.)
- Individual medical service
- Community health, education and civic betterment
- Medical research

The nominee may qualify on any one or all combinations of these points. Reasons for the nominations should be clearly stated.

The Kentucky Medical Association Award is presented to an outstanding lay person in Kentucky each year in honor of his or her outstanding accomplishments in the field of public health and/or medical care.

The Awards Committee will have the responsibility to choose recipients of the KMA Distinguished Service Award and the Kentucky Medical Association Award. Any county society or individual member may suggest nominees to the committee.

The awards are presented at the President's Luncheon during the annual meeting.

AWARD NOMINATION FORM

Name: _____

Address: _____

Birth Date: _____ Place: _____

Marital Status: _____

Spouse's Name: _____

Children: _____

☐ Distinguished Service
Award (Physician)

☐ KMA Award
(Lay Person)

Education: _____

Military: _____

Membership in Professional Organizations: _____

Membership in Civic Organizations: _____

Honors and Awards: _____

(Describe nominees qualifications and other pertinent information which the Awards Committee may consider in making its decision.)

Name of Person or Group Submitting Nomination: _____

Address: _____

Phone: (Home) _____

(Office) _____

Please fill in and mail to: KMA, Attn: Awards Committee, 4965 US Hwy 42, Ste 2000, Louisville, KY 40222-6301

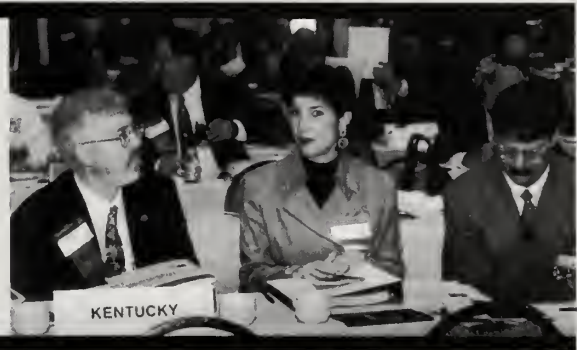
Deadline for receiving nominations is July 15.

American Medical Association Organized Medical Staff Section (AMA-OMSS)

invites your medical staff to be represented at the

1999 Annual Assembly Meeting, June 17-21, in Chicago

Vision Voice Victory



*If physicians want to be effective agents for change in improving today's health care, they need **a vision, a voice, and a victory.***

The AMA-OMSS looks to medical staffs across the country for a **vision**. This vision gets a **voice** at the AMA-OMSS Assembly Meeting. This voice carries to the AMA House of Delegates, is amplified and acted on to score a **victory** at the national, state and/or local level. This victory may be new legislation, health care policy reform, improved quality standards, or the creation of resources to help physicians and their patients at home.

Be part of the process. Send a representative* from your medical staff to the **1999 Annual AMA-OMSS Assembly Meeting, June 17-21, in Chicago**. *There is no fee to attend.*

OMSS representatives can:

- Submit resolutions prior to the Assembly meeting.
- Testify at Reference Committee hearings and vote in the Assembly.
- Participate in special issues forums.
- Network at state and regional caucuses.
- Earn up to 9 hours of CME credit** (*Topics include: physician compensation, coping with stress, the computerized patient record, credentialing for new procedures, influencing physician behavior through quality improvement and cost containment efforts, medical staff development plans, physician-patient dynamics, and federal and state government action.*)

For more information on how to register, call 800 626-3211 and ask for the Department of Organized Medical Staff Services or e-mail us at omss@ama-assn.org.

* Must be an AMA member

** The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The American Medical Association designates this educational activity for up to 9 hours in Category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

American Medical Association

Physicians dedicated to the health of America



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Manuscripts — Articles will be accepted for consideration with the understanding that they are original and are contributed solely to this *Journal*. The transmittal letter should designate one author as correspondent and include the author's address and telephone number. Receipt of manuscripts will be acknowledged and unused manuscripts returned. All material is reviewed by the Board of Editors and publication of any article is not to be deemed an endorsement of the views expressed therein.

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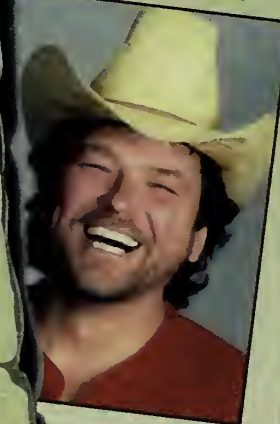
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COVER:

In the May issue of The Journal, a UofL surgeon clarified the various conditions responsible for abnormal head shapes in children. Clinical findings and treatment methods for these children appear in an article beginning on page 248 of this issue.

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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Periodical postage paid at Louisville, KY and additional offices. Yearly subscription rates: \$35 domestic; \$45 foreign. Single issues \$4 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222. Telephone 502/426-6200 Fax 502/426-6877 Email member@kyma.org

Listed in *Index Medicus*. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

EDITORIAL AND ADVERTISING:

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Printed by the Ovid Bell Press, Inc, Fulton, Missouri 65251.

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MY FINAL AMA HOUSE OF DELEGATES REPORT



*I want to thank all of
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serve in this capacity.
It has been a labor of
love and I certainly
have enjoyed it.*

At the December meeting of the House of Delegates, there were many important issues discussed and adopted that will have far-reaching effects as to the future of the AMA—well into the next century. The most important of these is the Ad Hoc Committee on Governance Report. Some of the highlights of this adopted report include:

- The goals of the Strategic Plan should become an overarching part of all Board and council meetings, with all new initiatives and emerging issues regularly measured against this plan.
- AMA Bylaws to be amended to include a Chair and Chair-Elect as officers of the Board, each limited to a single one year term, with the Chair-Elect automatically succeeding to the Chair, and precludes the Chair from immediately running for President-Elect. This was done to take the politics out of these positions and allow full-time attention to be given to the business of the AMA.
- A committee of the House will determine the structure and establish the amount of compensation for the Board of Trustees annually.
- It better defines the role of the Board in its oversight mode; that in addition to its financial and legal responsibilities, it is to include risk management, policy integration, stakeholder involvement, advocacy, communications, and strategic planning.
- The Bylaws will be amended to clarify the Board's responsibility as one of oversight, with the Board referring all operational business matters of the AMA to the Executive Vice-President. It will reflect the Board's principal role as one of oversight

and not day-to-day management of the AMA affairs.

- The House is to approve strategic priorities for the AMA and directs the Board in providing a strategic plan. After the Board approves the strategic plan, it will be forwarded to the House for comment and recommendations and their final approval.

In addition, the Speaker of the House of Delegates will initiate an evaluation of the functioning of the House of Delegates and make recommendations for improvements. They should address the management of the large volume of business before the House and see that the deliberation of the House will be better focused and more effective in integrating its work with the AMA's strategic plan.

There is much more in this report as it is very comprehensive, and I encourage all of you to get a copy and read it.

This will be my last *Journal* article as I am retiring from the House at the end of the year. I want to thank all of you for allowing me to serve in this capacity. It has been a labor of love and I certainly have enjoyed it. I want to thank the AMA delegation for all their wonderful support through the years and I can assure you, you are being left in good hands.

Thank You.

Donald C. Barton, MD

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NEWS FOR KENTUCKY PHYSICIANS

Follow the Money or Where Did the Medicaid Managed Care Savings Go?

The media is absolutely in a frenzy, fretting over the shortage of Medicaid funds that have traditionally gone to health departments for indigent care. When Medicaid managed care becomes a reality in a particular region, funds for health departments suddenly dry up. Several legislators are wringing their hands over this awful situation. We thought you might be interested in the dialogue that took place on January 19, at the Interim Committee on Health and Welfare, between Senator Ernesto Scorsone (D) Lexington, and Medicaid Commissioner Dennis Boyd. For you "readers on the run," we highlighted the important stuff.

Q. Senator Scorsone: How much money is in the Medicaid Trust Fund?"

A. Commissioner Boyd: "NONE."

Q. Senator Scorsone: "In October 1995, the language of the

waiver stated Kentucky would get the waiver but any savings in the Medicaid budget had to be placed in the Medicaid Trust Fund and those moneys have to be used to expand the delivery of health services to indigents, and if this isn't done the Medicaid waiver would be revoked. Have there been any changes that would modify the waiver with HCFA since October 1999?

A. Commissioner Boyd: "Not to my knowledge."

Q. Senator Scorsone: "When the administration put forth the budget for health services, it identified 3% to 5% savings from the Medicaid budget as a result of managed care innovation. In the first year, the savings would be \$70 million and the second year would be \$117 million. How can Kentucky get around the requirement of the HCFA waiver that the \$187 million

MONITORING Medicine

should have been placed in the Medicaid Trust Fund and used only for the expansion of delivery of health care to the indigent?"

- A. Commissioner Boyd: "The reduction of the \$180 million was in the overall budget that was approved and wasn't money appropriated to the Department for Medicaid Services that would represent savings *but was extracted from the Depart-*

ment in advance and applied to other state initiatives.

- Q. Senator Scorsone: "Were there any savings?"

- A. Commissioner Boyd: "Within the moneys appropriated to the Department for Medicaid Services, there are no savings realized in this respect, because they were provided with a budget that the administration recommended and the

General Assembly approved that gave the Department a specific amount to operate the department."

Senator Scorsone said, "Kentucky is either realizing savings with managed care or not. If we are, those moneys should be in the Medicaid Trust Fund and used for the expansion of care for the indigent. If not, the federal government could revoke the waiver.

KMA News Review

Below are synopses of news items that have appeared recently in various publications regarding issues of interest to Kentucky physicians.

- With the number of uninsured increasing by as much as 1 million a year, a new study shows that physicians whose incomes depend most heavily on managed care devote only half as much time to charity care as do physicians who do not participate in managed care. Another study showed that in states where Medicaid programs rely most heavily on managed care, uninsured patients were less likely to have a regular physician or have visited a physician in the last year. According to the AMA, physicians perform approximately \$11 billion worth of free or discounted care in one year. *[The Washington Post]*
- Surveys conducted of managed care companies estimate an average premium increase across all types of plans of 8.7% for the coming year, up from 7% last year. One expert said the rise in costs comes from the fact that 85% of employees are enrolled in managed care plans so employers cannot achieve cost savings by moving employees into such plans. The survey also found that while employers would like to shift employees into HMOs, employees would rather join PPOs for greater choice. Finally, the survey found that HMO premium costs will grow "fast or faster" than the cost of traditional indemnity plans. *[Managed Care]*
- If state and federal regulators approve the proposed Aetna/Prudential merger, it would make the company the nation's largest HMO with 22.4 million beneficiaries. One observer noted that Aetna would become "the Goliath of the giants" in the health care industry, giving credence to the projections by others that the health care market will be dominated by a handful of HMOs in the next century. *[Managed Healthcare]*
- A study conducted of Medicaid managed care programs in rural areas suggests rural Medicaid providers experience increased competition, face new financial challenges, must make changes in services and staffing, and must cope with increased administrative burdens under Medicaid managed care. The study also found that extra time and effort is needed to establish a Medicaid managed care system in rural areas, which may then lead to a successful capitation program in those areas. *[Health Affairs]*
- A General Accounting Office report found that Medicare HMOs routinely "distribute inaccurate or incomplete information" to Medicare recipients regarding benefits and the need for referrals. *[Wall Street Journal]*
- The Senate Special Committee on the Year 2000 Technology Problem reported that the health care industry is "one of the worst prepared" for the Y2K problem, in which many computers will be unable to read the year 2000 causing problems within the system. The report also said that 90% of physicians' offices have done nothing to address the problem. Medicare is having significant problems addressing the issue as well. *[Health Lawyers News]*
- Two radiation oncologists were recently awarded \$22.8 million by a jury in Tampa, Florida when a hospital violated its bylaws by failing to renew the physicians' privileges. The hospital then granted an exclusive contract to the University of Miami Medical School. In another case, a neonatologist was awarded \$2 million when Mt. Sinai Medical Center directed sick babies to other physicians employed by the facility. In both cases, the physicians claimed the actions were taken for financial rather than medical reasons. *[Bureau of National Affairs Health Law Reporter]*

CLINICAL FINDINGS AND TREATMENT OF CHILDREN WITH ABNORMAL HEAD SHAPES

Michael J. Sundine, MD

Children with abnormal head shapes have received recent attention in both the lay press and the medical literature. The key distinction is determining whether the child has deformational plagiocephaly, which results from external molding forces, or plagiocephaly resulting from craniosynostosis or premature cranial suture fusion. Treatment of craniosynostosis generally involves surgery, whereas deformational plagiocephaly can usually be managed nonoperatively.

CLINICAL FINDINGS

The concerns surrounding patients with craniosynostosis can be divided into functional and aesthetic. The functional concerns include elevated intracranial pressure, hydrocephalus, mental retardation, ocular findings, and neuropsychiatric considerations.

Since there is continued brain growth in children with craniosynostosis in a constricted cranial vault, there exists the potential for elevated intracranial pressure. In a classic study by Renier et al,¹ intracranial pressure monitoring was performed in 75 patients with confirmed craniosynostosis, including 37 patients with single suture synostosis and 38 patients with multiple suture involvement. The intracranial pressure was defined as normal (<10 mmHg), borderline elevated (11-15 mmHg), and

increased (>15 mmHg). The study demonstrated that 14% of patients with single suture synostosis had elevated intracranial pressure, and 47% of patients with multiple suture synostosis had elevated intracranial pressure. Renier et al¹ also noted a decrease in the intracranial pressure in the patients who had cranial vault reshaping.

Craniosynostosis may be associated with hydrocephalus. In a review of 250 patients with craniosynostosis, Golabi et al² were able to identify 10 patients with hydrocephalus by either computerized tomography (CT) scan or ventriculogram. Further analysis of the patients revealed that four patients had Pfeiffer syndrome, three had Crouzon syndrome, two had kleeblattschädel anomaly, and one had sagittal synostosis. Fishman et al³ reported on a series of 14 patients with hydrocephalus who also had craniosynostosis and found that eight had Apert syndrome (Table 1). In fact, the literature shows that kleeblattschädel anomaly and Apert syndrome are most frequently associated with hydrocephalus.

The issue of mental retardation in patients with craniosynostosis is controversial. The incidence of mental retardation is lowest in those patients with single suture synostosis, except for patients with metopic synostosis, which is associated with forebrain defects. The incidence is highest in those patients with Apert syndrome and kleeblattschädel anomaly. An impor-

tant issue in this regard is the potential effects of elevated intracranial pressure on intelligence, especially in those patients with multiple suture synostosis. Renier et al¹ demonstrated a statistically significant relationship between intelligence quotient (IQ) and elevated intracranial pressure at the time of surgery. However, they were not able to rule out other potential factors that could be responsible for this association. In contrast, Kapp-Simon et al⁴ were unable to demonstrate that cranial suture release had any effect on subsequent mental development, even though it did improve the shape of the cranial vault.

Mental retardation may also be associated with craniofacial dysostosis syndromes. Apert syndrome has frequently been associated with mental retardation. There are few, if any, controlled studies on the intellectual outcome of these patients. Some of these patients are presumed to have decreased intelligence based on their appearance, and many have been institutionalized, with limited social interaction, which may contribute to this impression. The presence of multiple suture synostosis and possible elevated intracranial pressure, with potential effects on intelligence, add another confounding variable.

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Table 1. Syndromes associated with craniosynostosis

Syndrome	Characteristics
Apert Syndrome	Bicoronal synostosis with turribrachycephaly, exorbitism, severe midfacial retrusion, and bilateral symmetrical syndactyly of the hands and feet.
Carpenter Syndrome	Craniosynostosis, preaxial polydactyly, brachydactyly, clinodactyly, short stature, and obesity.
Crouzon Syndrome	Exorbitism, retromaxillism, inframaxillism, and paradoxical retrogenia.
Kleeblattschädel Anomaly	Most severe syndrome; may involve numerous deformity combinations of sutures of the calvarium, skull base, and face.
Pfeiffer Syndrome	Craniosynostosis, midfacial hypoplasia with exorbitism, and broad thumbs and toes.
Saethre-Chotzen Syndrome	Craniosynostosis, a low hairline, upper eyelid ptosis, brachydactyly, and partial cutaneous syndactyly.

For more complete information, refer to "Abnormal Head Shapes in Children: Classification and Syndromes" in the May 1999 issue.

Craniosynostosis can affect any aspect of visual function.⁵ Errors of refraction, dysfunction of the nasolacrimal system, upper eyelid ptosis, corneal exposure related to globe proptosis, malposition of the medial and lateral canthus, and extraocular muscle dysfunction have all been reported. Of special concern is the potential effect of elevated intracranial pressure. Elevated intracranial pressure secondary to craniosynostosis may lead to papilledema and if left untreated, may lead to optic atrophy and vision loss. For this reason, the ophthalmologist is an essential member of the craniofacial team.

The psychosocial consequences related to the altered appearance of children with isolated craniosynostosis and the craniofacial dysostosis syndromes can be profound. The children often become objects of ridicule from their classmates because of their abnormal head shape and/or associated facial difference.

HISTORY AND PHYSICAL EXAMINATION

Patients with single suture craniosynostosis generally have a history of an abnormal head shape that was noticed at birth and does not seem to improve with time. Patients with deformational plagiocephaly, however, may have an abnormal head shape due to positional molding in the immediate postnatal period, or they may have a normal head shape at birth that may progress to abnormal due to torticollis or sleeping position, for example. When the child with deformational plagiocephaly is able to sit up and develops head control, there may be spontaneous improvement in the head shape. The deformity seems to improve with time, as long as its cause has been removed.

Craniofacial dysostosis syndromes are generally recognized early in the postnatal period because of their associated anomalies. Patients' parents should be questioned about the presence of lethargy, irritability, or vomiting, which are signs of elevated intracranial pressure. The presence of elevated intracranial pressure is particularly important in syndromal patients due to the frequent occurrence of multiple suture stenosis.

Physical examination of the head and neck will reveal the characteristic deformities noted earlier. There may be palpable ridging over the involved sutures, which is seen most commonly in metopic synostosis and sagittal synostosis and is less common in anterior and posterior plagiocephaly. The anterior and posterior fontanelles should be examined to determine whether they are open. An open and tense fontanelle suggests elevated intracranial pressure.

The child's neck should be checked for range of motion. Lack of a full range of motion to both sides suggests the presence of torticollis or a cervical vertebral abnormality. Torticollis can be treated with physiotherapy and in rare cases, may require surgical release of the sternocleidomastoid muscle. The children should also have a careful eye examination and neurologic examination. Occasionally, abnormal positioning of the eyes in primary gaze will cause secondary skull deformities or so-called ocular torticollis.

RADIOLOGIC FINDINGS

The diagnosis of craniosynostosis can generally be confirmed from the history and physical examination alone. Radiographs may be valuable in the diagnosis, but several limitations were noted by Bruneteau and Mulliken:⁶

- (1) The lack of mineralization of the neonatal cranium may obscure some of the characteristic changes that occur in craniosynostosis.
- (2) The stenosis of the suture may begin near the base of the skull and may not be detected due to overlapping shadows from the basicranium.
- (3) Secondary changes related to the presence of pathologic sutures may not be obvious in the neonatal period.
- (4) The synostotic process may involve only a small area of the involved suture in the neonatal period and thus may not be detected on plain x-ray films.

The typical findings on plain x-ray films may be divided into primary, related to the pathologically involved suture, and secondary,

related to progression of the deformity from the craniosynostosis. Primary radiologic findings include perisutural sclerosis, localizing beaking, bony bridging, and inability to visualize the involved suture. Secondary radiologic signs seen in anterior plagiocephaly include the presence of the "harlequin orbit," where the lesser wing of the sphenoid is deviated superolaterally, and there is deviation of the nasal root.⁶ When the child with craniosynostosis has elevated intracranial pressure, the secondary changes of cortical thinning of the calvarium and "thumbprinting," a beaten metal appearance of the calvarium, may be noted.

Computerized tomography can be also used to diagnose craniosynostosis, but should not be used to screen for the presence of craniosynostosis. The CT scan is quite useful in the treatment phase, especially when formatted with a three dimensional reconstruction, for characterizing the skeletal pathology, and also for detecting the presence of associated abnormalities such as hydrocephalus and other brain abnormalities. Magnetic resonance imaging (MRI) has little value in the evaluation of craniosynostosis.

TREATMENT

Deformational Plagiocephaly

Patients with mild deformities may need no specific treatment other than positioning the child such that pressure is placed on the more prominent areas of the skull, and also encouraging upright positioning as much as possible. Patients with moderate-to-severe deformities are recommended for molding helmets. Finally, the children with severe deformities that have been resistant to molding therapy may require surgery to correct the head shape.

The use of a molding helmet appears to be most effective when started before 6 months of age, although excellent results can be obtained if the molding helmet is started later. It should be worn essentially 24 hours a day, but can be taken off for bathing and skin care. The helmet needs frequent weekly to biweekly adjustments

by the orthotist. The child is seen every 6 weeks to 2 months by the craniofacial surgeon to evaluate the progress of the therapy. The molding helmet is worn until the optimal head shape is obtained or when there is no further improvement. Generally, the helmet is not worn after the child is 18 months of age.

The molding helmet is custom made to each child's head. A plaster cast of the skull is made, and from this cast a positive mold is created. This positive mold is then used to create the molding helmet. The helmet is designed to apply pressure to the prominent areas of the skull and allow brain growth to expand the flattened areas; thus, normalizing the skull shape. For example, in a patient with right occipital flattening secondary to positional plagiocephaly, the molding helmet would be designed to place pressure on the right frontal and left occipital areas.

Craniosynostosis

Surgery for the treatment of craniosynostosis is varied according to the suture(s) involved, the child's age, and whether or not the child has a craniofacial dysostosis syndrome. The treatment of single suture synostosis is generally a one-time procedure; whereas, syndromal patients often require multiple surgical procedures to optimize their appearance.

In both syndromal and isolated craniosynostosis, the patients undergo procedures directed to the orbits and cranial vault at 6 to 12 months of age. These procedures aim to normalize the shape of these areas, in addition to increasing the cranial volume after relieving the growth restriction. A consequence of the volume expansion is the presence of "soft spots" where calvarium is not present. The dura at this age has powerful osteogenic potential and can produce bone to fill in these soft spots. The ability of the dura diminishes after the child has reached 18 months of age, and procedures performed later may leave permanent cranial defects.

While it has been believed that earlier operation would result in the most normalized appearance, there are some limitations. At 3 months of age, the bone is quite fibrous and

does not hold a shape well. The bone is also of poor quality for bony fixation and will not hold a screw well. Finally, recent evidence indicates that the promise of early operation improving aesthetic results has not been realized.^{7,8}

In situations where early operation is clearly indicated, functional concerns outweigh the aesthetic concerns, such as in patients with papilledema or elevated intracranial pressure where the cranial volume needs to be expanded to reduce the intracranial pressure. In general, however, we would ideally prefer to perform the cranio-orbital reshaping procedures at approximately 1 year of age.

The second time period when craniofacial procedures are performed is from 5 to 7 years. This period is important for several reasons. The calvarium changes from a single layer to the adult configuration of three layers. Since the osteogenic potential of the dura is minimal at this age, all calvarial defects must be completely filled. The calvarium can be split in the diploic space, and the inner layer may be used as a source of bone graft material, while the outer layer can be returned to its normal location. Further, the cranio-orbital area is approximately 90% developed, and thus, a surgical procedure should have a negligible effect on subsequent growth. This should also be the last operation performed in this region of the craniofacial skeleton. Finally, psychosocial concerns are important at this age as the child prepares to enter elementary school.

Children who require procedures at this age are usually syndromal with accompanying midfacial deficiency. The procedures are directed to the cranial vault, orbits, and midface. The most commonly performed procedure in this population is a subcranial LeFort III osteotomy, which reproduces the lines of the LeFort III fracture and advances the inferior orbits, nose, zygomas, and maxilla. A repeat cranio-orbital reconstruction may be needed to complete the reconstruction of the upper face and forehead region following the LeFort III procedure.

The final age group where surgical procedures are performed is when the children reach skeletal maturity. This occurs in women from

age 14 to 16, and in men from age 16 to 18. The operations performed in these age groups are directed at the maxillary growth deficiency seen in patients with craniofacial dysostosis syndromes, and they correct the midface deficiency and level the occlusion. The procedures performed include LeFort I osteotomy, bilateral sagittal split osteotomy, and sliding genioplasty.

Sagittal Synostosis

Sagittal synostosis (Figures 1A and 1B) is unusual compared with other forms of craniosynostosis in that early surgery, before 6 months of age, is advocated. Further, it is the one form of craniosynostosis where strip craniectomy, or resection of the involved suture, seems to be effective. Thus, if an infant presents with sagittal synostosis before the age of 6 months, a strip craniectomy with barrel staving of the skull will return the head shape to normal. Those patients who present after 6 months of age will require a total cranial vault reshaping, where the entire calvarium is removed from approximately 1 cm above the supraorbital rim to 2 cm below the external occipital protuberance. A strut of bone is reconstructed over the sagittal sinus, which is shortened in the anteroposterior direction. The remaining calvarial segments are recontoured and plated to the sagittal strut of bone, but they are allowed to float laterally. The end result is shortening in an anteroposterior direction and widening of the previously constricted biparietal area.

Anterior Plagiocephaly and Trigenocephaly

Anterior plagiocephaly (Figure 2) and trigonocephaly (Figure 3) are treated at approximately 1 year of age. Following a coronal incision, a bifrontal craniotomy is performed by neurosurgery. The supraorbital bar is removed, keeping a posterior extension for bony fixation. The supraorbital bar is reshaped and plated back to the skull in an advanced position. In patients with trigonocephaly, a bone graft may be inserted between the two halves of the supraorbital bar to camouflage any associated hypo-

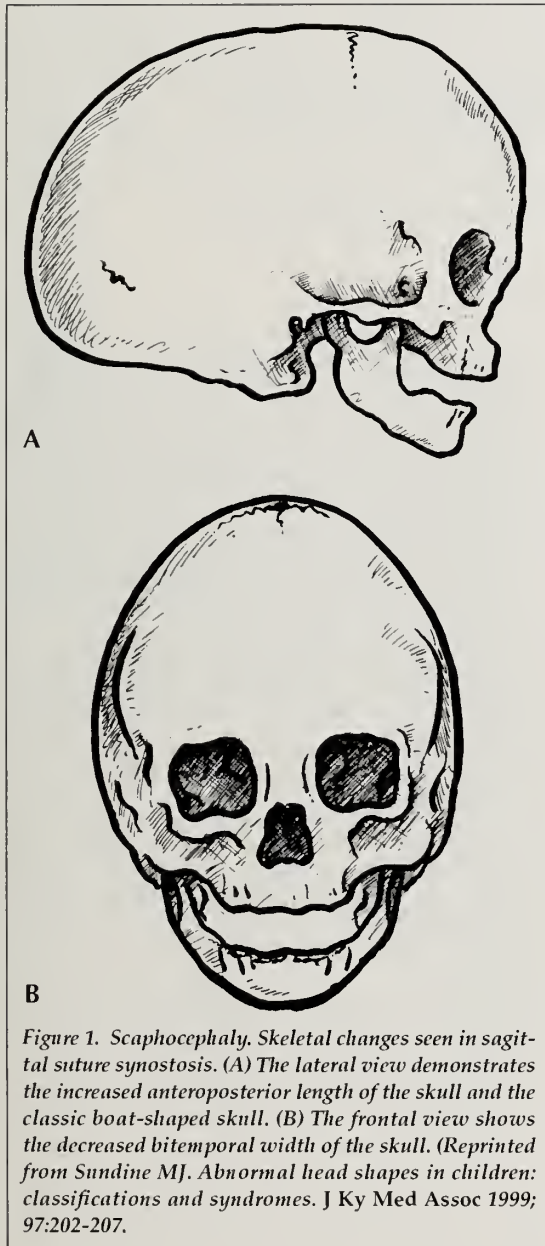


Figure 1. Scaphocephaly. Skeletal changes seen in sagittal suture synostosis. (A) The lateral view demonstrates the increased anteroposterior length of the skull and the classic boat-shaped skull. (B) The frontal view shows the decreased bitemporal width of the skull. (Reprinted from Sundine MJ. Abnormal head shapes in children: classifications and syndromes. J Ky Med Assoc 1999; 97:202-207.

telorism. The calvarium is reshaped and attached back to the supraorbital bar.

Posterior Plagiocephaly

The treatment of posterior plagiocephaly is essentially the opposite of anterior plagio-

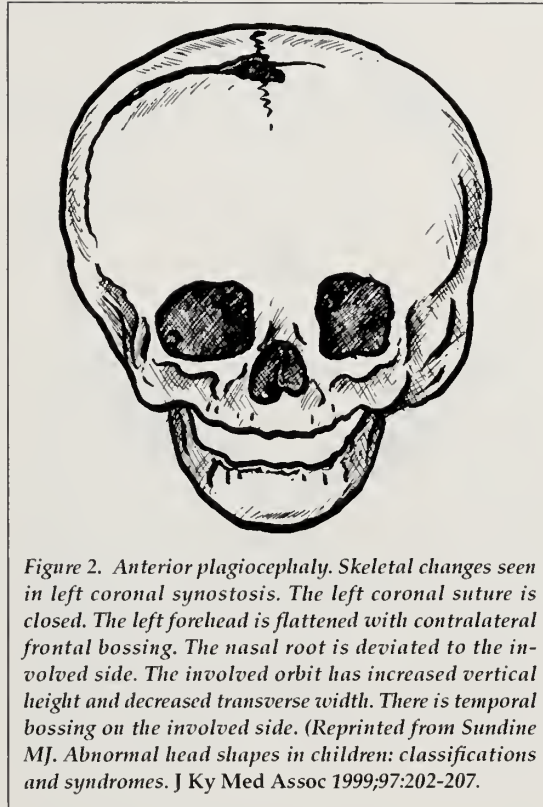


Figure 2. Anterior plagiocephaly. Skeletal changes seen in left coronal synostosis. The left coronal suture is closed. The left forehead is flattened with contralateral frontal bossing. The nasal root is deviated to the involved side. The involved orbit has increased vertical height and decreased transverse width. There is temporal bossing on the involved side. (Reprinted from Sundine MJ. Abnormal head shapes in children: classifications and syndromes. J Ky Med Assoc 1999;97:202-207.

cephaly. An occipital bandeau is created and reshaped after a bilateral parietal-occipital craniotomy is performed. The bandeau is fixed into position, and the calvarial segments are reshaped and plated into position.

COMPLICATIONS

Despite the magnitude of the procedures involved in the treatment of craniosynostosis, the complication rates are surprisingly low. The potential complications include brain or eye injury, blindness, hemorrhage, infection, and even death. In a multicenter study involving six centers and 793 patients, the authors noted an overall complication rate of 16.5%.⁹ There were 13 deaths (1.6%), and two patients had diminished vision in one eye. A subsequent study by Munro and Sabatier¹⁰ reported on 2019 operations in 1092 patients. They reported a

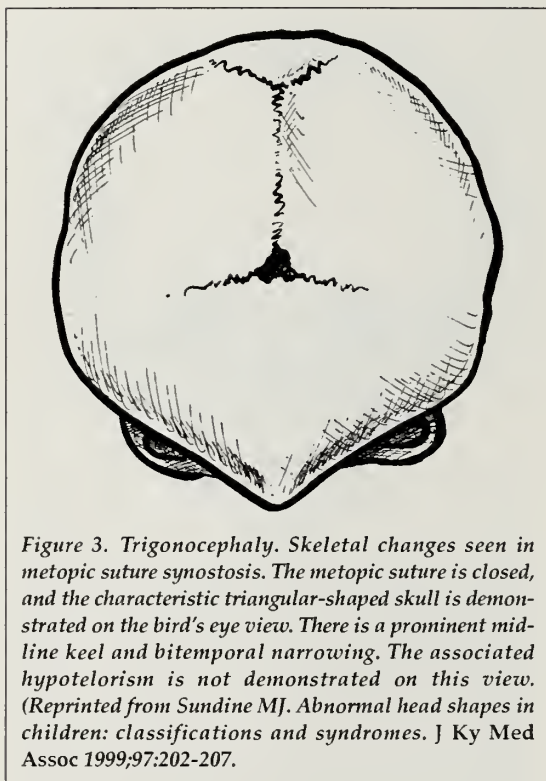


Figure 3. Trigenocephaly. Skeletal changes seen in metopic suture synostosis. The metopic suture is closed, and the characteristic triangular-shaped skull is demonstrated on the bird's eye view. There is a prominent midline keel and bitemporal narrowing. The associated hypotelorism is not demonstrated on this view. (Reprinted from Sundine MJ. Abnormal head shapes in children: classifications and syndromes. J Ky Med Assoc 1999;97:202-207.

major complication rate of 14.3%, and the overall mortality rate was 0.64%. The most frequent complication in their series was infection (5.3%).

SUMMARY

Craniosynostosis and deformational plagiocephaly are causes of abnormal head shapes in infants and children. Craniosynostosis may involve a single suture or multiple sutures. In

most cases, a careful physical examination can distinguish between these two entities. Deformational plagiocephaly can usually be remedied without an operation. Using appropriate craniofacial techniques, excellent aesthetic results can be obtained in the treatment of patients with craniosynostosis.

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VALUE OF PREOPERATIVE LOCALIZATION STUDIES PRIOR TO INITIAL NECK EXPLORATION FOR HYPERPARATHYROIDISM

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Hyperparathyroidism is a condition characterized by excess secretion of parathyroid hormone and represents the most frequent cause of hypercalcemia in the United States today.¹ An estimated 100,000 new cases are seen in this country each year. This condition occurs 3 to 4 times more often in females than males and increases with age.

Based on etiology, hyperparathyroidism may be classified primary, secondary, or tertiary. Primary hyperparathyroidism is caused by single or multiple adenomas, hyperplasia (which involves all parathyroid glands), or parathyroid cancer. Ninety percent of primary hyperparathyroidism is due to single parathyroid adenoma. Hyperplasia represents 6% to 8% of primary hyperparathyroidism; multiple adenomas 2% to 4%; and parathyroid cancer is extremely rare—only 1% or 2%. Secondary hyperparathyroidism occurs in individuals with chronic renal failure and is the response of the parathyroid glands to low blood calcium from continued calcium excretion through the kidneys, which occurs as a result of the loss of the concentrating capabilities of the damaged kidney. Tertiary hyperparathyroidism is also seen in renal failure patients. In this condition autonomous abnormal parathyroid production occurs due to chronic stimulation of hypocalcemia.

The treatment of hyperparathyroidism in any form involves the identification and excision of the abnormal secreting parathyroid gland(s). This may be easier said than done because the anatomic location of normal parathyroid glands may vary, abnormal glands may

gravitate from a normal location to an abnormal location, there may be more or less than the usual number (4) of parathyroid glands, and parathyroid glands may reside in aberrant locations such as the mediastinum.

There is little debate regarding the appropriateness of preoperative localization studies for patients who are being re-explored following either a failed neck exploration or for recurrent hyperparathyroidism.

The controversy surrounding preoperative localization studies prior to initial exploration of the neck for hyperparathyroidism continues, often fueled by inconclusive studies of the value of the various imaging techniques.¹⁻⁴ As technology changes and improves, the usefulness of these imaging studies requires re-examination. It has been suggested that the most important preoperative localization in untreated patients with hyperparathyroidism is a surgeon experienced in parathyroid surgery.²

This retrospective study represents the experience of faculty at the University of Louisville Department of Surgery with preoperative localization studies carried out prior to initial or primary neck exploration on patients with hyperparathyroidism over a 21-year interval.

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Table 1. Preoperative Localization Studies Before Initial Neck Exploration for Hyperparathyroidism

Study	Number of Patients
None	77
Technetium Sestamibi Scan	29
Computed Tomography Scan	31
Ultrasound	18
*Other	5
TOTAL	160
*MRI & Technetium Thallium	

Table 2. Accuracy of Preoperative Localization Studies

Study	Correct Localization of Abnormality %
Technetium Sestamibi Scan	83 (24/29)
Computed Tomography	65 (20/31)
Ultrasound	67 (12/18)

MATERIALS AND METHODS

Data was collected from patient records at four University of Louisville affiliated hospitals (University of Louisville Hospital, Jewish Hospital, Norton Hospital, and the Veterans Affairs Medical Center) by independent evaluators (DG and RCGM) from November 1976 to February 1997. Both primary and tertiary hyperparathyroidism were included and re-explored hyperparathyroid patients were excluded. Documentation of the duration of surgery was obtained from the anesthesia record and was defined as the time from incision of the skin to closure of the skin. Analysis of data was conducted using the SPSS program.

RESULTS

Preoperative localization studies were conducted in 52% (83/160) of patients before initial neck exploration for hyperparathyroidism (Table 1). Precise identification of the abnormality in the neck by any of the preoperative

imaging techniques occurred in 55% (46/83) of patients and the correct side of the neck was indicated in 73% (61/83) of patients. The technetium sestamibi scan was superior to either computed tomography scan (CT) or ultrasound (Table 2). The limited experience with MRI and technetium thallium precluded inclusion in the analysis. These studies were carried out in three University of Louisville affiliated hospitals (University of Louisville Hospital, Jewish Hospital, and Norton Hospital) and, therefore, do not represent the experience of a single institution.

Cost Effectiveness

Hospital charges and reimbursements, professional charges, and reimbursement data were collected in December 1997 (Table 3). The hospital charges cover a fairly wide range, often at considerable variance with the actual reimbursement. Computed tomography scan costs were the highest in professional and hospital charges and reimbursement. Ultrasound costs were the lowest while technetium sestamibi scan was a little more expensive. Magnetic resonance imaging (MRI), technetium thallium, and selective venous sampling, were not included in the analysis because of the very small experience with these studies. The cost of MRI and selective venous sampling are substantially higher than the sestamibi scan, CT or ultrasound.

Outcome

Return to normocalcemia was essentially the same when preoperatively studied patients were compared to a group of patients having neck exploration without preoperative localization (Table 4). The lower percentage of return to normocalcemia in the group of patients undergoing preoperative ultrasound is not statistically significant. The majority of patients who did not undergo preoperative localization were explored bilaterally. A large proportion of this group represents tertiary hyperparathyroidism explored by the transplant service. The majority of patients studied by sestamibi scan

or CT had unilateral exploration directed by the imaging study findings.

Duration of Surgery

The mean duration of surgery for the group undergoing unilateral neck exploration (101 minutes) is less than the mean duration of surgery for bilateral neck exploration (143 minutes). Within the unilateral exploration group, patients studied preoperatively by sestamibi scan, CT, or ultrasound demonstrated a modest decrease (10 minutes) in the mean duration of surgery, compared with patients explored without preoperative localization (Table 5). In addition, outcome defined as permanent postoperative normocalcemia is somewhat better for the group of patients studied preoperatively. In the bilateral neck exploration group, there was no difference in the duration of surgery or outcome comparing patients with and without preoperative localization studies.

DISCUSSION

Over half of the patients in this review had some type of preoperative localization study prior to neck exploration. During this 21-year time period, many technologic changes occurred in preoperative localization capabilities. Employment of the various imaging techniques, at any point in time, represents our experience with these evolving technologies. More recently, the technetium sestamibi scan has become the preoperative localization study of choice in untreated patients with biochemical diagnosis of hyperparathyroidism. Our preference for the technetium sestamibi scan is based on a higher level of accuracy, both reported in the literature,

Table 3. Cost of Initial Neck Exploration Preoperative Location Studies

Study	Professional Charge	Professional Reimbursement	Hospital Charge	Hospital Reimbursement
Technetium Sestamibi	\$156	\$78	\$460-466	\$86.52
CT with Contrast	\$300	\$150	\$601-1100	\$198.22
Ultrasound	\$134	\$67	\$70-310	\$67.83

Table 4. Extent of Neck Exploration and Outcome

Preoperative Localization Study	Unilateral Exploration %	Bilateral Exploration %	Outcome* %
None	13 (10/77)	87 (67/77)	91 (70/77)
Technetium Sestamibi	69 (20/29)	31 (9/29)	93 (27/29)
Computerized Tomography	71 (22/31)	29 (9/31)	100 (31/31)
Ultrasound	28 (5/18)	72 (13/18)	83 (15/18)

*Permanent Normocalcemia

Table 5. Comparison of Duration of Surgery and Outcome Using Preoperative Localization for Patients With Untreated Hyperparathyroidism

Preoperative Localization Study	Unilateral Neck Exploration		Bilateral Neck Exploration	
	Mean Duration of Surgery Minutes	Successful Outcome* %	Mean Duration of Surgery Minutes	Successful Outcome* %
None	106	90 (9/10)	142	91 (61/67)
Technetium Sestamibi†	96	96 (45/47)	143	90 (28/31)
Computerized Tomography				
Ultrasound				

*Permanent Postoperative Normocalcemia

† Preoperative Localization by One or More of These Studies

as well as our own clinical experience (Table 2).⁵⁻¹¹ We believe that our experience with the technetium sestamibi scan has increased validity because it represents a study used in multiple institutions.

The ongoing impact of health care reform has had a major effect on radiology charges and reimbursement. Table 3 contains late 1997 charges and reimbursements for the three most frequently employed preoperative localization imaging studies. Major variances between the charges and reimbursement exist. The reim-

bursement for these radiologic studies are fairly standard in all Louisville area hospitals and has fallen sharply in recent years. A recent publication of preoperative imaging study costs from a neighboring regional center, demonstrates how rapidly and sharply these costs have been lowered.¹² When the accuracy of the technetium sestamibi scan is combined with the current relatively low reimbursement, this test has become very cost effective.

In this study, the mean duration of surgery for unilateral neck exploration was 42 minutes less than bilateral neck exploration with essentially the same outcome. In the unilateral exploration preoperative localized group, the length of surgery was shortened by 10 minutes and the outcome improved by 6% compared to patients undergoing unilateral neck exploration without preoperative localization studies. Neither of these findings are of statistical significance.

The controversy over the use of preoperative imaging studies involves issues of accuracy, invasiveness, and cost. Recent improvements in technology and reduction in cost have increased the value of these studies. In our view, preoperative imaging studies are of limited usefulness in patients with tertiary hyperparathyroidism who will undergo bilateral exploration because of anticipated multigland disease or for patients with primary hyperparathyroidism where the surgeon plans to carry out bilateral exploration of the neck. When unilateral exploration of the neck is an option in untreated patients with primary hyperthyroidism, we would propose that preoperative imaging is helpful in guiding the surgeon to the side of the neck most likely to harbor the dysfunctional gland. In this study, under these circumstances, preoperative localization modestly reduced the duration of surgery and resulted in a somewhat improved outcome compared to similar patients undergoing exploration of the neck without prior localization studies.

The technetium sestamibi scan represents the most reliable preoperative localization test. Our experience is consistent with that of others indicating an accuracy rate in single gland disease in the 85 to 100% range. The technetium ses-

tamibi scan is the least operator dependent and represents a very cost effective study compared to CT, MRI, or some of the other more invasive preoperative localization studies. Recent reduction in reimbursement for this test have substantially increased the cost effectiveness.

Outside of endocrine referral centers, the probability of single gland disease in patients with primary hyperparathyroidism exceeds 90%.¹³⁻¹⁵ We would propose that the high accuracy and low cost of technetium sestamibi scan justifies routine use in all patients with primary hyperparathyroidism for the purpose of directing the surgeon to one side of the neck in anticipation of unilateral neck exploration. Under other circumstances such as tertiary hyperparathyroidism or reluctance to perform a unilateral neck exploration, we do not feel that a preoperative sestamibi scan adds anything but increased costs to the surgical management of primary hyperparathyroidism.

More recently, the sestamibi scan has become an integral part of a radioguided minimal access approach to neck exploration for hyperparathyroidism (Figure 1). If single gland disease is identified following sestamibi scan, the residual radioisotope in the gland can be used to guide the exploration intraoperatively. The gamma probe (a hand-held Geiger counter) identifies the location of the radioisotope thus guiding the exploration. Confirmation that the abnormal gland has been identified and removed is achieved by assay of circulating parathyroid hormone. This assay which takes 10 minutes compares pre- and postexcision parathyroid hormone levels. A 50% or greater fall in the postexcision parathormone hormone level indicates with 90% confidence that the abnormally secreting parathyroid gland has been removed.¹⁶ When this approach is possible, a smaller incision is made with less extensive dissection in the deeper tissues of the neck. Most patients are discharged on the same day as surgery. No drains are required. There is minimal postoperative discomfort and eventually no postoperative management other than wound care for a relatively small incision and the necessity of postoperative calcium blood sample.

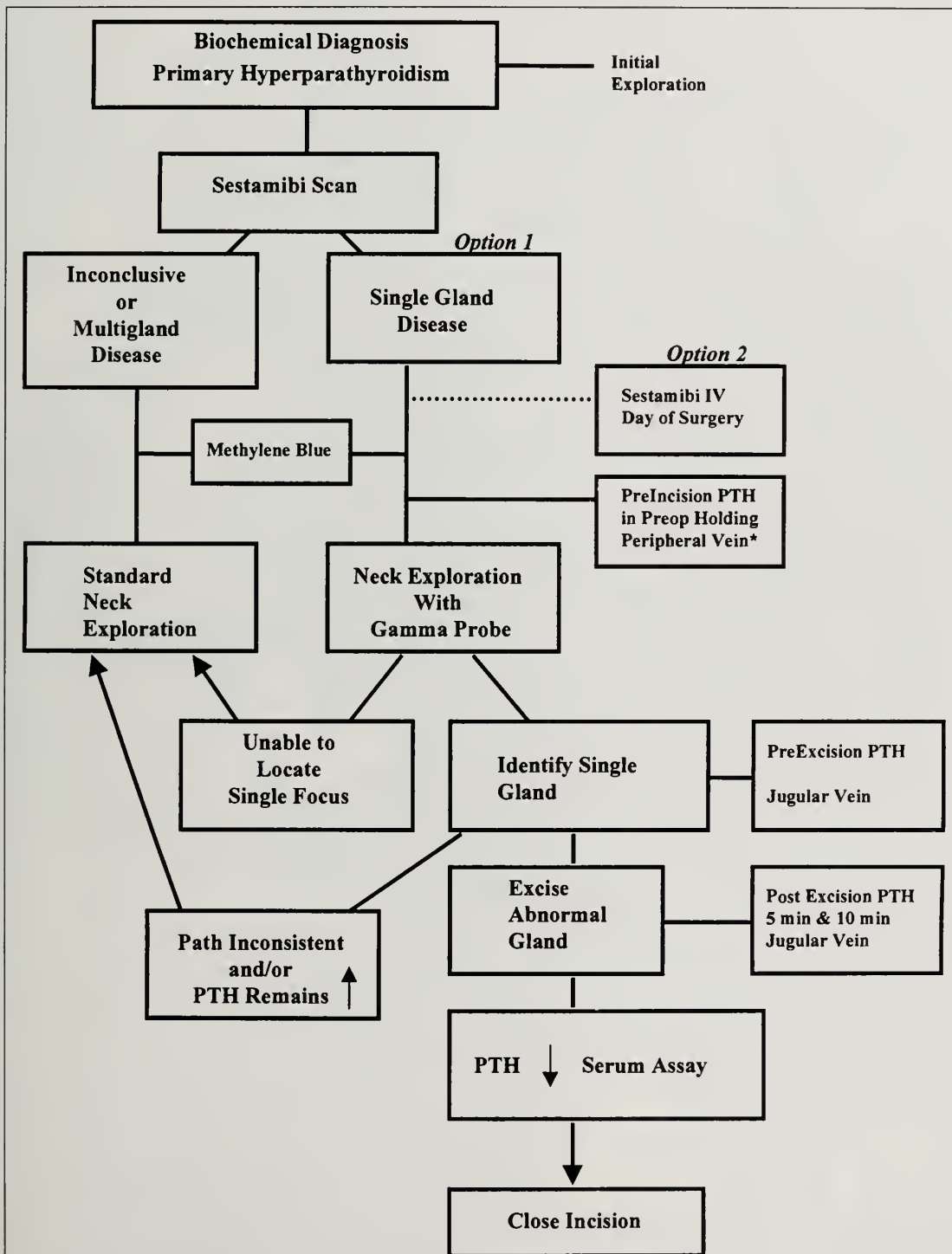


Figure: Parathyroid neck exploration with gamma probe.

Option 1: Preoperative scan and exploration on same day.

Option 2: Preoperative scan and exploration on different days.

*Clear tubing with 15cc before drawing blood or draw blood while inserting IV.

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WILLIAM B. MONNIG, MD SECRETARY, GOVERNING COUNCIL, ORGANIZED MEDICAL STAFF SECTION

Four KMA members serve in elected leadership roles in the American Medical Association. For a relatively small delegation of five Delegates and five Alternate Delegates, that is a significant accomplishment.

To inform you, our members, on what is taking place on your behalf at the AMA, the Journal is publishing interviews about the involvement, thoughts, and observations of these four leaders—"The AMA Connection."

This month we profile William B. Monnig, MD, Secretary, Governing Council, Organized Medical Staff Section. The April Journal profiled Robert R. Goodin, MD, Member, AMA Council on Medical Education, and the May Journal profiled Ardis D. Hoven, MD, Council on Medical Service. This series will conclude in July with a profile of Bruce A. Scott, MD, Member, Board of Trustees, Young Physicians Designated Position.

JKMA: Please give our readers a brief history of the Organized Medical Staff Section (OMSS).

Dr Monnig: When the Organized Medical Staff Section was originally designed in about 1982, it was considered somewhat on the fringe of AMA membership. It was intended to give grass roots physicians an opportunity to actively participate in AMA policymaking and have dialogue with the leaders of the AMA. That is still a major function of the OMSS. It now consists of rep-



resentatives of not only hospitals, but also any other economic entity composed of physicians.

In order to be a representative to the Organized Medical Staff Section of the AMA, the person needs to be an AMA member and be selected by the organization they represent. It presents a great opportunity for direct input by the physician who doesn't feel the usual methods of getting his voice heard are working at the AMA.

Anyone who represents an organization of physicians can be a legitimate representative to the OMSS. As long as 15 years ago, we realized that one national organization isn't easily accessible by every physician, in the sense that

they can't all go to the Interim and Annual Meetings. So we recommended that state Organized Medical Staff Sections be created, and we have such an organization in Kentucky. I was the original Chair of this group, John O'Brien is the current Chair, and Don Swikert preceded John. Each new Chair has done a better job than the Chair before them. John has done a great job in accumulating a number of educational materials.

JKMA: What is your involvement with the Section?

Dr Monnig: Currently, I serve as Secretary to the Governing Council of the AMA-OMSS. I was fortunate enough to have participated in the OMSS originally as a representative of my hospital, Saint Elizabeth in Northern Kentucky. About seven years ago, I was elected to one of seven positions on the Governing Council. The Governing Council is a democratic group. Titles are relatively unimportant in our deliberations.

JKMA: What major task is your group currently undertaking?

Dr Monnig: Basically, trying to educate physicians about how to participate in the organization to accomplish certain core values that we hold near and dear to our hearts. These core values involve physician self-governance. We believe that physicians should be in charge

of patient care, especially the quality of that care, and that encompasses creating a credentialing process, a privileging process, and peer review. It also obviously is directly related to quality assurance, and to some degree, it has direct relevance to disciplining physicians if there are quality issues. We found over the past 15 years that we have created enough policy in most cases to address almost every new issue that comes up. The biggest problem is in implementing the policies that the AMA already has.

About two years ago, we revisited our purpose as an organization. We realized that many physicians no longer hold the medical staff of the hospital as their most important relationship, and in fact, physicians were joining economic entities to be able to deal with managed care. Therefore, we expanded our membership to those types of organizations. We also realized that even our organization was getting "long in the tooth," that the same people who wanted to be the new representatives of the AMA 15 years ago were still the same people. So we have tried to encourage young people to be part of our organization.

As most people realize, there is also a Young Physicians Section of the AMA, but we have a different constituency. As young physicians get interested in organized medicine they rapidly cross over into areas of our influence. So we have actually had collaborative meetings, joint meetings with the Governing Council of the Young Physicians' Section to develop educational

materials and programs that we usually put on at both the Annual and Interim Meetings of the AMA.



JKMA: *How are issues the Council deals with and their priorities determined?*

Dr Monnig: The issues that are important to the OMSS deal with representation of the working physician—the physician who day in and day out is seeing patients. We try to address the problems that physician has in dealing with managed care, in dealing with the government, and sometimes in dealing with organizations that he has decided will be his representative way of interfacing with government and managed care.

Our top priority in the past year has been to develop a set of principles to help physicians organize and force outside agents to recognize. Again, it gets down to the role of physicians in credentialing, privileging, peer review. If standards are going to be set or critical pathways on how to treat patients, physicians need to be intimately involved

in those processes regardless of what organization is involved.

We actually encouraged Alice Gosfield, chair of the National Commission on Quality Assurance (NCQA) Board and a well-known health care attorney, to develop a paper on the principles by which we expect physicians to abide. Also, principles that we would like the American Hospital Association, NCQA, Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), and independent physician associations, as well as HCFA, to all agree must be met in the development of their organizations. That paper has been published. It has re-

sulted in Resolution 706, which was passed by the AMA House of Delegates at the last meeting. It said the AMA will take this set of principles and make contact with various external organizations and try to get them to adopt these principles. We have done that; we have met with HCFA. In fact, I just got back from a meeting where we had the opportunity to discuss these principles with the leaders of HCFA. We have met with NCQA, we have met with the JCAHO, and this week we invited a group of physicians who are leaders of viable economic physician organizations to see if they concur with those principles and how they might further develop those principles in their organizations.

Dr Whitelaw, who happens to be a delegate to the AMA, is president of the Sutter Group in California, and he met with us. Dr Richard Dixon is the head of a

California IPA, and he actually led a group of us in discussion for a day about how we could convince physicians that they had the capabilities of organizing and implementing the principles that we hold near and dear to us.

There was a long discussion that most physicians inherently are independent. They aren't very interested in being part of an organization unless they are the leaders of the organization, and everybody else has to do what they want them to do. We had an interesting discussion about what it will take to develop leaders of organized medical groups. In this case, we are not necessarily talking about organizing in the sense of the KMA or AMA, but in organizing into economic groups that foster these principles as the doctors are taking care of their patients. We believe that if we can make these principles known to the average physician and if the AMA is the vehicle through which physicians learn the skills to work together to advocate for their patients, that the average physician will see value in AMA membership. Obviously, one of our main goals is to achieve a large enough membership in the physician community to allow us to be effective representatives of physicians.

JKMA: *What is the greatest strength of this Council?*

Dr Monnig: Probably its diversity—and yet its focus on representing the interests of organized groups of physicians in dealing with regulatory agencies, with organized medicine itself, and also with the private regulatory bodies such as the JCAHO and NCQA. We have been able to have direct



meetings with those types of organizations attempting to set the standards for the quality of care, whether that is in HMOs, which is what NCQA does, or the JCAHO, which does that for hospitals. We have had great influence in espousing the interests of patients and organized groups of doctors to be the body that sets the quality standards that patients will be treated by, rather than having an administrative group take over those responsibilities. We have regular meetings with representatives of the JCAHO. We have been protective of standards for the Medical Staff Section. In fact, I'm going to a meeting in Chicago in a few days for that purpose.

JKMA: *What area of your Council needs more effort?*

Dr Monnig: If I have a regret about the OMSS concept, it is that there are 7,000 hospitals in the United States, and well over 100 hospitals in Kentucky, but a number of hospitals choose not to be represented at the state level or to go to the national meetings. Those groups are

missing a great opportunity to 1) understand the policies that impact their day-to-day practice, 2) to change those policies, and 3) to be exposed to how to be more effective leaders and representatives of their groups. Those programs are inherent to the meetings at the AMA. They are also inherent to the meetings that the Kentucky Medical Association Organized Medical Staff Section conducts.

JKMA: *AMA membership in Kentucky continues to be stable, although AMA membership has been declining over the past few years, nationally. Why, in your opinion, should physicians support the AMA?*

Dr Monnig: There is no organization that I can think of that is more democratic than the American Medical Association. If you have a good idea, you get the opportunity to present it, you can talk about it, and if you learn the processes you can even create resolutions that become AMA policy. The best place for that to start is actually in your county medical society. Or, if you are not an active member of the local med-

ical society, start as a representative of a hospital, or now as a representative of a large group whether it be an IPA, HMO, or whatever. If it is physician organized, you can be the representative to the AMA-OMSS. You can propose policy changes in the form of resolutions at either the OMSS or the AMA House of Delegates. Anything that is passed by the OMSS that is pertinent to the House of Delegates and pertinent to national policy will then be transmitted to the House of Delegates, and the House of Delegates will choose whether to agree with it or not. If they agree with it, it becomes the policy of AMA.

Physicians who fail to consider membership in the AMA or drop membership because their own economic well-being is shrinking, are making a mistake. There isn't any other place to look other than organized medicine. We need our county medical societies; we need the Kentucky Medical Association and every other state association; but we also need a national umbrella organization.

JKMA: *What do you see as the greatest impediment to AMA membership?*

Dr Monnig: AMA membership, unfortunately, not only entails recruiting new members, but retention of members. Retention is the biggest problem AMA is facing. Certainly physicians who form large groups have a harder time understanding why every member of their group should be an AMA member. A problem arises when you can send in one dues and get most of the benefits for the entire group. So we do focus our strategic plans based on both retention of

existing members and offering products available only to members of the AMA.

JKMA: *The AMA House of Delegates made some significant changes in the structure and governance of the AMA. Can you describe some of these changes and how they will affect the membership and the operation of AMA?*

Dr Monnig: The most recent change, started by the OMSS that has caused a significant amount of controversy, is a resolution that mandates that the AMA Board of Trustees needs to create a viable, collective bargaining organization for physicians. As of last week, the AMA Board of Trustees decided not to immediately implement this action called for by the House of Delegates. They haven't yet published their report as to why they thought that was the prudent thing to do. However, I can assure everyone that the governing council of the AMA understands the economic plight of the average practicing doctor; that those doctors who, for whatever reason, do not want to organize themselves into an economic entity, like a large group practice, should still have the ability to collectively negotiate with HMOs and the government when it comes to the stipulations of a contract, which we have to adhere to in order to deliver care to large populations of people. We realize that there are anti-trust laws.

We also are very supportive of the Campbell Bill. The Campbell Bill is a bill introduced by Representative Campbell of California that will allow collective bargaining by physicians. It is one of the main legislative initiatives of the

AMA. Our problem is, as everyone knows, rarely do you get a clean bill through Congress on its first try, or even its second try. I don't think physicians are willing to wait 10 years to solve the problem of how they can get their point across to managed care and HCFA. So we are supporters of the legislative effort, but we believe other efforts need to be tried.

JKMA: *What is the most critical issue facing the AMA? What should be done or is being done?*

Dr Monnig: The most critical issue currently facing the AMA is probably membership, in the sense that AMA needs to be perceived by the world as *the* representative of physicians. That ability is eroding, because every time we bring up the issue, the other party always says, "You don't even represent a majority of physicians."

It is in everyone's best interest to promote membership in the AMA or to create another organization just like the AMA. It doesn't make any sense to recreate the wheel. If there are things wrong with the AMA, then we need to correct them. That gets down to the issue of how the AMA is restructuring itself. I think I can assure everyone that the Board of Trustees, the subcommittees of the House of Delegates, and the upper echelons of management of the AMA are all researching ways to make the AMA a more efficient representative.

JKMA: *In what area does the AMA need to expend more effort?*

Dr Monnig: I think a key is to better coordinate the strengths of specialty groups. I'm a very strong advocate of specialty societies. They

are probably the best place to create policy and judgements about the best care for specific problems. As a urologist, even though I am a strong advocate for urology, I realize we aren't going to dominate medicine, because urology only makes up two percent of all the health care cost in the country. So we need to be able to bond together with the orthopedic doctors and the family doctors and the internists, and in order to do that, you need this umbrella organization.

There are plenty of opportunities for doctors of all ages and all varieties to participate. We think we have created a niche, if you will, for a group of physicians through the Organized Medical Staff Section, both to become leaders of physician groups and to be educated. We are an integral part of the overall picture of the AMA—not independent, not a radical group, but a group that is trying to represent the grass roots physicians in the political process of the AMA. It is a great place for leadership development.

JKMA: *What changes or new directions would you like to see occur for the AMA?*

Dr Monnig: I would like to see the American Medical Association develop more products. I don't mean gadgets to buy, but products on leadership development, organizational skills, or how to deal with the Sixth Scope of Work of the Professional Review Organization. Things that physicians need to know—such as how to make sure you stay in compliance so that fraud and abuse don't swallow you.

JKMA: *Patient Protection was the primary legislative goal of AMA in*

1998. While congress failed to enact patient protection reforms in 1998, what is the outlook in 1999? What other AMA legislative goals are we seeking in Washington?

Dr Monnig: We obviously are strong advocates of the Patient Protection Act. We've already discussed the AMA legislative goals on collective bargaining. Many of the problems with fraud and abuse are regulatory issues, not necessarily legislative issues. As far as dealing with the Office of the Inspector General, dealing with the Justice Department, dealing with HCFA, there is not anybody else that can do that effectively for physicians. Having

their own doctors' thoughts about the problem. Even though it is a national issue, there needs to be coordination and participation by physicians at the local level.

The AMA and AMPAC, KMA and KEMPAC work extremely well together. Our staff at the KMA has been very effective in getting the messages to our Congressmen and Senators about how organized medicine feels. Sometimes doctors become perturbed about the position of organized medicine because it isn't identical to theirs. I don't think those people understand the legislative process. It is great to have a personal viewpoint, and we need to express those personal



been in the AMA offices in Washington, I can confirm that we have a dedicated staff that is dealing with both the regulatory and legislative issues on a national scale. It is obvious that many of the votes Congressmen and Senators take on national issues are greatly influenced by what they perceive as

viewpoints to the right people. Those people are your county medical societies and your state medical societies. But when the state medical society digests your idea and brings out a consensus opinion in the form of a resolution or a report, the leaders of the KMA or the leaders of the AMA are obligated to

support that process. And that solution that everyone recognizes is probably a compromise of many peoples' best ideas. We cannot create a law that is going to meet each individual person's idea of their own individual best interests.

JKMA: *Do you wish to comment on the recent termination of the editor of JAMA?*

Dr Monnig: I thought it was a sudden reaction. Anyone who has actually read the article that sort of "tripped the trigger" to make this decision has to realize that the information in that educational material was dated in 1993. It had no new information in it whatsoever, and the only conclusion that I can draw is the editor who chose to publish that information in 1999 had a political agenda. This is a political agenda that does not deserve to be represented and is not representative of the best interests of the AMA. I had no problem with that person being let go and a new editor taking over, which is exactly what happened. It also is not a process that lends itself easily to prolonged discussion. The House of Delegates can't easily take on that issue and say, "Well, should we fire them or shouldn't we fire them?" I do think the House of Delegates has set up a set of principles that says, "We want our edi-

tors to be independent of the whim of the political feeling of physicians at the moment. We *do want* those articles to have a scientific basis." I do not think that was compromised by the firing of the editor. I would like to think that that would not take place very often. But, I also think we should give our Board of Trustees and our administrative leaders the power they need to be effective. In my opinion, that is what happened in this case.

JKMA: *One final question. You've held numerous leadership positions at the state level with KMA, and for several years have circulated with top leaders at the national level with AMA. How does KMA measure up from the standpoint of benefits to members, its leadership, etc?*

Dr Monnig: There is not another organization that is better than KMA at advocating for the positions that the House of Delegates passes. We have an extremely efficient staff. I can assure everybody that we have the best staff in the whole country. I've told staff that for the past 15 years, and I still mean it. In the past few years, having had the opportunity to deal with both elected and administrative leaders of the AMA, I've found that they are also extremely competent. The AMA is obviously a much bigger organization than

KMA, and has whole departments to deal with single issues. While both the AMA and KMA focus heavily on legislation, for example, the AMA's size, and larger based constituency, allow it to address other areas in great depth. Because of this depth of activity, there is a lot of staff specialization and several very competent leaders to help coordinate issues. At the KMA level, as most people know, many people wear many hats. So communication is a little bit easier, but it certainly is as effective a state medical association as there is in the country.

JKMA: *Do you have other comments?*

Dr Monnig: Involvement in organized medicine is crucial if we are to maintain medicine as we have known it. Involvement requires a lot of time, energy, travel, and being away from one's practice. But, if we are to continue to *have a practice*, we must make sacrifices, we must be involved. I have a passion for medical practice—so I must have an equal passion for organized medicine. These two dynamics can't exist without the other. I wish all physicians could appreciate how vital this participation continues to be.

Interview and photos by Sue Tharp, Managing Editor, JKMA.

BECAUSE THIS IS NO PLACE
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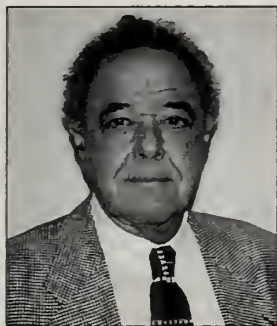


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A. Evan Overstreet, MD

SHOOT THE MESSENGER

*Editors of eminent
scientific journals
have spoken.*

On January 15, 1999, Dr E. Ratcliffe Anderson, Executive Vice President of the American Medical Association, dismissed Dr George D. Lundberg, editor of the *JAMA*. The reason for the dismissal was the publication of an article from the Kinsey Institute reporting a survey of 599 students of a midwestern college. Fifty nine percent were of the opinion that oral-genital play did not constitute "having sex." Although the survey had been conducted eight years remote from current events, Dr Anderson said its publication interjected *JAMA* into a major political debate and had nothing to do with science or medicine.

Dr Anderson stated that for seven months he had lost confidence and trust in Dr Lundberg's ability to preserve the editorial integrity of *JAMA*. This imperious action is reminiscent of the methods of the people's independent counsel, a player in the major political debate to which one presumes Dr Anderson refers. His dismissal of Dr Lundberg is in fact the event that has destroyed the integrity of *JAMA*.

Editors of eminent scientific journals have spoken.

The *Lancet*: *JAMA* is no longer part of a free press.

The *New England Journal of Medicine*: Firing an editor for expediting a review and advancing the date of publication is an irrational decision and an ominous precedent.

The *Journal of the Kentucky Medical Association*: An eye for an eye, a job for a job.

A. Evan Overstreet, MD
Editor



Carolyn Daley

KMA ALLIANCE "SERVICE TO KENTUCKIANS SINCE 1923"

The Kentucky Medical Association Alliance, "serving Kentuckians for over 75 years," will in 1999-2000 promote literacy and reading to young children, promote a permanent health education program in our schools-Growing Healthy, promote the S.M.A.R.T (Students Made Aware Reject Tobacco) program in the schools, promote the SAVE (Stop America's Violence Everywhere) program, provide health-related articles to our newspapers, educate the public about organ donation, osteoporosis, and breast cancer, promote donations to medical schools through the AMA Foundation, have a voter registration drive, and will develop a homepage on the Internet.

Thank you to the members of the 1999-2000 KMA Alliance Board for your commitment to improving the health and quality of life of the citizens of Kentucky. We look forward to working with the Kentucky Medical Association as we dedicate ourselves in service to all Kentuckians.

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Carolyn B. Daley
KMAA President

Member-Get-a-Member Campaign a Success With 68 New Members

W

ith 68 new KMA members attributed to the 1999 KMA Member-Get-A-Member Campaign, KMA President Don R. Stephens commended the efforts of all participants and recognized the top recruiters at the April Board of Trustees meeting.

Initiated at last year's KMA Annual Meeting, over 60 KMA delegates and members signed up to participate in the peer-to-peer recruitment campaign which lasted five months. Numerous efforts were undertaken across the state by individual physicians and at the March 1 deadline, 17 recruiters qualified for one of the four awards offered.

Earning the top award—a laptop computer—for gaining 10 or more new members were:

- **Baretta Casey, MD, Pikeville** (14 new members)
- **Harry Carloss, MD, Paducah** (12)
- **James Wright, MD, Louisville** (10)
- **Fayette County Medical Society** (10)

Recruiters who enlisted from one to three new members received a leather attaché:

- **David Allen, MD, Louisville**
- **Donald Barton, MD, Corbin**
- **Jack Borders, MD, Ashland**
- **Harold Bushey, MD, Barbourville**
- **Danny Clark, MD, Somerset**
- **Paul DeLuca, MD, Danville**
- **Meredith Evans, MD, Middlesboro**
- **Daniel Ewen, MD, Winchester**
- **Charles Nichols, MD, Pikeville**
- **Mary Jo Ratliff, MD, Pikeville**
- **Thomas Slabaugh, MD, Lexington**
- **John Stewart, MD, Lexington**
- **Donald Swikert, MD, Florence.**

The Member-Get-A-Member Campaign also resulted in 15 new AMA members as well as new members for all the county medical societies involved. Names of the new members appear regularly in *The Journal*.



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*YOU CAN EARN GREAT REWARDS
FOR RECRUITING YOUR PEERS*

...and so they did!!



Dr Baretta Casey — 14 Members



Dr Harry Carloss — 12 Members



Dr Jim Wright — 10 Members



FCMS — 10 Members
Dr Andy Pulito accepting

SHIP, WE'RE ALL WINNERS!!



BOARD OF TRUSTEES SPRING MEETING

The KMA Board of Trustees met in regular session on April 14-15, 1999, at the KMA Building in Louisville. The Board members heard reports from Don R. Stephens, MD, President; William P. VonderHaar, MD, Secretary-Treasurer; Danny M. Clark, MD, President, Kentucky Board of Medical Licensure; Donald C. Barton, MD, Senior Delegate to the AMA; Richard F. Hench, MD, Chair of the Kentucky Medical Insurance Company Board of Directors; Rice Leach, MD, Commissioner, Department for Public Health; KEMPAC Board of Directors; and Mrs James Crase, President, KMA Alliance.

Top recruiters for the KMA Member-Get-A-Member Campaign were recognized.

Baretta R. Casey, MD, Pikeville; Harry W. Carloss, MD, Paducah; James A. Wright, MD, Louisville; and the Fayette County Medical Society each received a laptop computer for recruiting ten or more new members. Thirteen physicians received a leather attaché for recruiting at least one new paid member. The campaign generated 68 new KMA members.

Cabinet for Health Services Secretary John Morse reported on the progress of the Medicaid partnerships, the KCHIP program, and the UNISYS contract renewal negotiations.

The Board of Trustees adopted the budget for fiscal year 1999-00. In further action, the



House Speaker John W. McClellan, MD, right, was seated with Vice Speaker Thomas K. Slabaugh, MD.

Board approved the nominees for election to the KMIC Board of Directors: William B. Monnig, MD, Edgewood, and William P. VonderHaar, MD, Louisville.

Richard Miles, MD, Russell Springs, was appointed to the Physician Advisory Committee to Health Kentucky; and Janet M. Connell, Administrator, Nephrology Associates of Kentuckiana, was named to the Committee on Managed Care. Wally O. Montgomery, MD, Paducah, was nominated for reappointment as KMA's representative on the Kentucky Hospital Association Board of Trustees.

Additional reports were given by the Committee on National Legislative Activities, the Committee on State

Legislative Activities, the Public Education Committee, the Committee on Child and School Health, the Committee on Physical Education and Medical Aspects of Sports, the Ad Hoc Committee on Cardiovascular Services Network, the Committee on Community and Rural Health, and the Council for Continuing Medical Education.

The Board also heard information on membership; the Annual Meeting; and communication activities including practice management seminars, trustee district meetings, and hospital medical staff meetings.

The KMA Board of Trustees will hold its next regular meeting on August 4-5, 1999, at the KMA Building.



Chair, Board of Trustees, J. Gregory Cooper, MD, listened closely to the report being presented.



President-Elect Harry W. Carloss, MD, left, and Secretary-Treasurer William P. VonderHaar, MD, pondered the issues.



President Donald R. Stephens, MD, presented Immediate Past President C. Kenneth Peters, MD, with a personalized bound volume of the 1998 Journal of the Kentucky Medical Association.



AMA Delegate and State Legislative Chair Wally O. Montgomery, MD, left, and AMA Delegate and National Legislative Chair Donald C. Barton, MD, are always available to share their wisdom and experience with the Board.

NEWSMAKERS

David H. Neustadt, MD, was honored by the Arthritis Foundation for a lifetime of achievement in the field of arthritis and rheumatic diseases. The special Arthritis Achievement Award was presented at the Annual Meeting of the Arthritis Foundation, Kentucky Chapter. Dr Neustadt has served the Chapter as President, Chairman of the Board, and Chairman of the Medical-Scientific Committee.

Dr Neustadt, who is also Clinical Professor of Medicine and former Chief of Rheumatology at the University of Louisville School of Medicine, is the author of numerous scientific articles and medical textbooks on rheumatology. In 1997, Dr Neustadt was the recipient of the American College of Rheumatology Distinguished Rheumatologist Award.

As part of the University of Louisville's 201st birthday celebration, 32 faculty members' research, service, and teaching efforts were lauded. Four KMA members were included in this group, described by U of L President John Shumaker as "faculty who have displayed examples of foresight, creativity, and excellence through their scholarship, teaching, and service to their profession, community, and university. I am very proud to call them colleagues."

The following vignettes summarize a look at what peers see in their nominated counterparts:

Stephen F. Wheeler, MD, helped to establish the Hope Clinic, a facility for homeless children staying in Central Louisville shelters that has become a favored site for students to work with faculty in providing care to this population.

He has also been a leader in integrating the curriculum of the primary care clerkship (which combined separate clerkships in internal medicine, family and community medicine and pediatrics), actively participates on the Educational Policy Committee of the School of Medicine, and frequently serves as a career counseling advisor to medical students.

Dr Wheeler is founder and director of HealthReach, a comprehensive program of fitness assessment and health promotion, and has lectured extensively on a variety of subjects locally and nationally.

His involvement with the American Heart Association includes educational and fundraising projects as well as being a spokesperson on issues such as nutrition, exercise and teen-age smoking.

Dr Wheeler is a frequent speaker at senior adult group meetings where his compassion and expertise in family medicine make him a favorite.

Under the leadership of **Bernard Weisskopf, MD**, U of L's Child Evaluation Center has become one of the premier programs for the provision of genetic and developmental services in the United States.

Dr Weisskopf, a pediatrics professor, is regarded as the first faculty member in the medical

school to focus on the importance of providing clinical genetic services to Kentuckians in a medical school setting and providing training to medical students and residents in the field.

His leadership efforts in the delivery of high-quality developmental services and health care also led to the creation of satellite clinic sites for individuals unable to commute to Louisville for services. More than 10,000 patients have been served at these clinics.

He also has played a key role in securing funding needed to create the Kentucky Autism Training Center and in establishing legislation to assist those with developmental disabilities.

In addition to devoting his time and talents to providing the best possible developmental services and health care to his patients, Dr Weisskopf has been invaluable in guiding and educating young faculty medical students.

The willingness of **Gordon R. Tobin, MD**, to offer pro bono service knows no national boundaries.

A surgery professor and director of the division of plastic and reconstructive surgery, Dr Tobin has worked with Children of the Americas for several years and specifically has done many surgical procedures on young children in Guatemala.

Dr Tobin has performed burn reconstructions and other reconstructive procedures to benefit individuals in third world nations and areas of need throughout the world.

He also has been involved in the management of burn patients from the Ukraine including a well

publicized case in which a young Ukrainian boy was brought to the United States as an abandoned child.

Dr Tobin also has sought to educate physicians and allied health personnel in the skills and techniques needed to care for these patients.

Most recently, Dr Tobin was involved in the history-making operation that made New Jersey native Matt Scott the first hand transplant recipient in the United States.

Julio A. Ramirez, MD, who chairs U of L's department of infectious diseases, helped develop the Louisville International Medical Conference that matches foreign and local physicians who share the same specialty.

The visiting medical professionals have the opportunity to attend lectures and case conferences, view surgical and laboratory techniques and discuss the latest medical technology with Louisville medical professionals.

Dr Ramirez also coordinates logistics including travel, translation and local medical care for children from Latin American countries as chair of the Jefferson County Medical Society's International Medical Committee. Heart, brain and thoracic surgeries have been performed at no cost to the children in need.

As a board member of Sister Cities of Louisville and co-chair of its LaPlata Committee, Dr Ramirez coordinated visits with host families, translators and transportation for teams from different countries that came to Louisville to participate in the MasterCard International Sister Cities Soccer Cup Tournament.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

BOYLE

Belinda Bart MD FP
109 Daniel Dr
Danville 40422
1995, Meharry Medical Nashville

CARROLL

Rostyslav Szwajkun MD PS
CCH 309 11th St
Carrollton 41008-1400
1986, Wayne State Detroit

CLARK

George Popham MD ORS
205 Floyd Clay Dr Ste 4
Winchester 40391
1993, U of Louisville

CLAY

Dana Edwards MD S
401 Memorial Dr
Manchester 40962
1986, U of S Alabama Mobile

DAVIES

Reda El-Shiekh MD C
314 E Hwy 66
Tell City IN 47586
1993, Cairo U Egypt

FAYETTE

James Bottiggi MD PD
100 North Eagle Creek Drive
Lexington 40504-2701
1975, U of Vermont
E Jane Brock DO AN
4832 Pleasant Grove Rd
Lexington 40515
1989, Kirksville College
Osteopathy

Edward Harder MD IM
1760 Nicholasville Rd Ste 501
Lexington 40503

1968, U of Alberta Canada
John Larrinaga MD R
2321 Old Hickory Ln
Lexington 40515

1988, U of S California
Julie Lindemuth MD IM
630 South Point Drive
Lexington 40515

1994, U of Texas Houston
Scott Mair MD ORS
UKMC Dept of ORS
Lexington 40536-0284

1991, Duke U
Peter Murray MD ORS
700 Bob O Link Dr
Lexington 40504

1985, West Virginia U Morgantown
Stephen Schindler MD IM
177 Burt Road
Lexington 40503

1992, U of Kentucky
Yuri Villaran MD PUD
2109 Palmbrooke Ct
Lexington 40515

1988, Cayetano Heredia Peru
JEFFERSON

Thomas Beck MD OBG
3701 Cypress Springs Pl
Louisville 40245

1991, U of Illinois Chicago
Maurice Linkous MD R
11600 Ridge Rd
Anchorage 40223

1987, U of Virginia Charlottesville
Robert Metz MD AN
10816 Foxgate Ct
Louisville 40223

1990, U of Louisville
Steven Nakajima MD
601 S Floyd St Ste 300
Louisville 40202

1982, St Louis U
Gary Reasor MD AN
250 E Liberty Ste 300
Louisville 40202

1988, U of Louisville

Lynn Reilly MD 8033 Dixie Highway Louisville 40258 1994, Albany Med Coll NY	IM	Ashish Patel MD 104A Woods Trl Richmond 40475 1988, Seth G S Med Coll India	IM	Lisette Garrett MD 401 Bogle St Ste 102 Somerset 42503 1991, Indiana U	PD
Christian Stewart MD 3803 Flowering Grove Ct Louisville 40241 1995, U of Louisville	IM	McCRACKEN		WARREN	
Thomas Yeh MD 201 Abraham Flexner Way Ste 1200 Louisville 40202 1986, Johns Hopkins	TS	Donald Billmaier MD PO Box 1410 Paducah 42002-1410 1967, Ohio State U	OM	Richard Welch MD 1320 Andrea St Bowling Green 42104 1994, U of Kentucky	FP
KNOX		Russell Carter DO 6508 Stinespring Dr Paducah 42001-8676 1990, Ohio U Osteopathy	GE	IN-TRAINING	
Ionel Tamasan MD 602 Knox St Barbourville 40906 1988, Faculty of Medicine Romania	IM	Russell E Shields MD 101 Deer Path Ln Paducah 42001 1991, U of Louisville	R	JEFFERSON	
LAUREL		MERCER		Joseph Langford MD Karen Lyons MD Kelly Manahan MD Svetlana Nakatis MD	EM OBG OBG FP
Nancy Morris MD 140 Reed Valley Rd London 40744-9797 1995, U of Kentucky	IM	Diane S Thomas MD 466 Linden Ave Harrodsburg 40330 1995, Med Coll of Ohio Toledo	PD	PERRY	
Cheung Shin MD 135 Kirkwood Dr London 40744 1965, Korea U	IM	NELSON		Vibeke Dankwa MD	FP
LAWRENCE		Anand M Gupta MD 3 Audubon Plaza Dr #520 Louisville 40217 1985, Malana Azad India	GE		
Lisa Fugate DO 18320 Cherrywood Dr Catlettsburg 41129 1994, West Virginia Osteopathy	FP	PERRY			
LETCHER		Joseph P Williams Jr MD 524 E Main St Hazard 41701 1961, U of California San Francisco	NS		
Bela Szaniszló MD Whitesburg ARH Whitesburg 41858 1963, Semmelweis U Hungary	EM	PIKE			
MADISON		Vicki C Rose MD 114 Walnut Dr Pikeville 41501-1916 1987, U of Kentucky	PD		
Hanan Budeiri MD 527 W Main St Richmond 40475 1979, Ain Shams U Egypt	IM	PULASKI			
		Michael Citak MD 26 Oxford Way Ste A Somerset 42503 1986, Vanderbilt	TS		

OBITUARIES

Carlo H. Tamburro, MD
Louisville, KY
1936-1999

Carlo H Tamburro, MD, a retired gastroenterologist, died January 29, 1999. A 1962 graduate of the University of New Jersey Medical School, Dr Tamburro was an active member of KMA.

Charles W. Morris, MD
Louisville, KY
1914-1999

Charles W Morris, MD, a retired psychiatrist, died February 1, 1999. Dr Morris was a 1940 graduate of the Indiana University School of Medicine and a life member of KMA.

Off-label Uses of Cancer Drugs

It has been brought to the attention of the Department of Insurance that many healthcare providers in this state are unaware of the provisions of House Bill (HB) 618, enacted by the General Assembly in the spring of 1998. This bill directed the Commissioner of Insurance to establish a panel of five medical experts, including three oncologists and two physicians, to review off-label uses of cancer drugs not included in any official compendia or in the medical literature. The panel, known as the Off-Label Drug Use Review Task Force, was appointed by Commissioner George Nichols III in the fall of 1998, and is currently involved in the development of a process for making recommendations to the Commissioner from time to time and whenever there is a dispute about payment for the off-label drug use. HB 618, also authorized the Commissioner to direct any person or agency which issues an insurance policy in this state to make payment for an off-label cancer drug as recommended by the task force, as well as any medically necessary service(s) associated with the administration of the drug. Meetings of the task force are publicized and open to the public. If you have

questions relating to the provisions of HB 618 or this task force, you may contact the Kentucky Department of Insurance, Division of Health Insurance Policy and Managed Care at 502.564.6088.

Domestic Violence CME Reminder

All licensed primary care physicians must complete a one-time, three-hour course on domestic violence no later than June 30, 1999. Primary Care as defined in KRS 164.925 includes those professionals practicing *family/general practice, general pediatrics, general internal medicine, emergency medicine, general obstetrics and gynecology, and preventive/public health*. Physicians who obtained licensure after July 1, 1996, are required to successfully complete the training within three years of the date of initial licensure.

The KMA Model Health Care Protocol on Abuse, Neglect and Exploitation, has been approved by the Governor's Council on Domestic Violence and the Kentucky Board of Medical Licensure as the course curriculum. Institutions accredited to provide CME (ie, hospitals, AHECs, and medical schools) are authorized to designate CME credit for this course. A videotape of the KMA Domestic Violence Seminar held September 1997 is also available for purchase.

this two-page document is available to KMA members.

Reminder on Change in Medicare Itemized Billing Policy

Beginning April 1, it became mandatory that physicians furnish an itemized statement upon written request from Medicare patients within 30 days or face civil monetary penalties. No charge can be assessed for the statement, which must detail each Medicare item or service rendered.

Drug Abuse History Said to Cause Mental Illness in African American Women with AIDS

The National Medical Association reports that researchers have found an increasing need to assess the cognitive effects of AIDS on African American women. In the November issue of the *Journal of the National Medical Association (JNMA)* researchers investigated both HIV-positive and negative drug users, as well as women with full-blown AIDS.

They found that women with a history of drug abuse who had AIDs suffered from cognitive deficits. However, HIV-positive drug users as well as HIV-negative drug users showed no evidence of mental illness.

As a control, researchers tested HIV-negative non-drug users against HIV-negative and positive drug users. Findings showed that HIV-negative non-drug users scored higher in their cognitive tests. Researchers believe their findings lend support to the theory that the deficits observed were related to drug use rather than HIV status.

KMA AT YOUR SERVICE

To request *Association* materials referred to in these capsules, contact KMA:

- Phone—502.426.6200
- Fax—502.426.6877
- Email—member@kyma.org

AdminaStar List of "Common Errors" Available

AdminaStar Federal, the Medicare carrier for the state of Kentucky, has compiled a list of "common errors" it finds in claims submitted by physicians. A copy of



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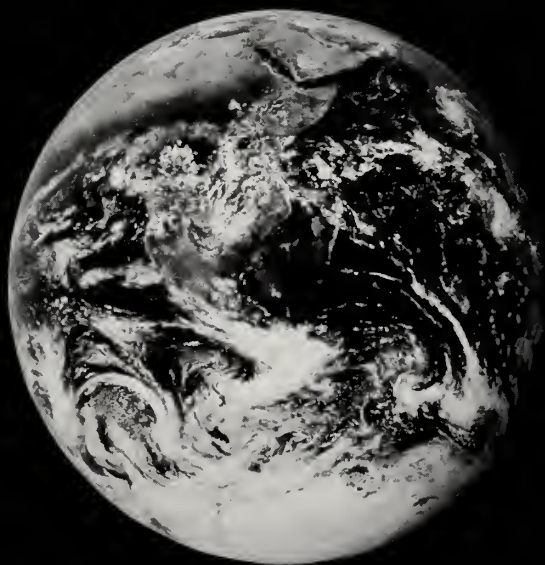
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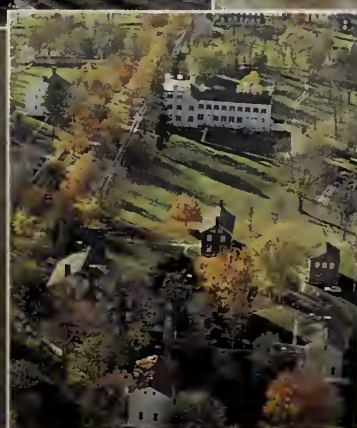
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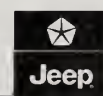
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Join us in Lexington, Monday through Thursday, September 27-30, for the 1999 KMA Annual Meeting. See page 296 for a short, informative article featuring the highlights of this thriving city.

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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Periodical postage paid at Louisville, KY and additional offices. Yearly subscription rates: \$35 domestic; \$45 foreign. Single issues \$4 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222. Telephone 502/426-6200. Fax 502/426-6877. Email member@kyma.org

Listed in *Index Medicus*. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

EDITORIAL AND ADVERTISING:

Contact Sue Tharp, JKMA, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222. Phone 502/426-6200; FAX 502/426-6877.

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Printed by the Ovid Bell Press, Inc, Fulton, Missouri 65251.

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Website: www.kyma.org

WHAT HAVE WE DONE—WHAT ARE WE DOING—WHERE ARE WE GOING



On July 31, 1999, the Physician component of the Provider Tax ends. The repeal of the provider tax, which cost Kentucky Physicians \$44,000,000 annually, was not simple. We got the job done by conducting a huge public, legislative, and political campaign. Your contribution to state revenue coffers will decrease, thanks to KMA action and support from Governor Paul Patton and members of the 1996 Kentucky General Assembly, \$11 million dollars this coming year. That campaign, the most successful campaign ever run by KMA, was coordinated and accompanied by determination, diligence, and just plain old hard work by KMA members.

Now we have other "fish to fry." In many ways, we perceive this association year as a period of goal setting and preparation. The various Committees, along with the Board of Trustees, have been busy implementing the long-range plan adopted by the 1998 KMA House of Delegates. As directed, the Association has concentrated on Membership, Legislation, Public Advocacy, and Professionalism. While this article will not dwell on all these categories, we will especially concentrate on issues relating to membership activities and patient care.

• MEMBERSHIP

The Board of Trustees has worked hand in hand with the Membership Department on recruitment and retention. We have enjoyed some success with innovative initiatives. Our "member-get-a-member" project is a success. However, 100% retention continues to be a struggle. On the national level, there is considerable internal and external discussion regarding membership in the Federation that includes Specialty, County, State, and National Medical Associations or Societies.

While we recognize the importance to our practice of belonging to our National Specialty Society, other components of the Federation are just as critical. Unfortunately, there are those who believe that Specialty societies can protect patients and represent medicine in the legislative, public, and regulatory arena. If we buy that "load of watermelons" we are in for a rude awakening. Kentucky is doing fairly well—approximately 50% of KMA members belong to AMA. Unfortunately, some physicians and staff selfishly promote "disunity," which only serves to "balkanize" the profession and destroy cohesiveness crucial to our survival. Many of us are particularly concerned for AMA. That concern exists not only within the profession, but outside as well. When the AMA stumbled as a result of the "Sunbeam" debacle, it made front page and editorial copy in every major newspaper and media outlet. Despite the media's philosophical leanings, they understand very well that AMA is THE major national voice for quality patient care. Silencing AMA's voice, which regularly speaks out for the uninsured, health and safety legislation, medical education, and quality medical care would be catastrophic. However, many politicians both conservative and liberal have joined the chorus of AMA critics—with good reason. Without the AMA in Washington there is no single, constant, and consistent voice for our patients and the profession. If the AMA voice is permanently silenced, medicine becomes a squawk box of 40-50 separate, selfish voices, all clamoring for individual attention, and representing narrow specialty interests. If that happens, we are finished.

● LEGISLATIVE AND REGULATORY

Several proposals relating to managed care and patient protection are primary goals of this Association. Don Barton's national legislative report on KMA's recent trip to Washington is included in this issue, and I will not elaborate on National legislation. Under Wally Montgomery's superb leadership, we have been busy preparing for the upcoming 2000 Kentucky General Assembly. Legislation has been drafted or is in the process to address the following issues.

● ALL OR NOTHING CLAUSES

KMA will propose legislation to prohibit so called "all product" clauses in any health insurance contract. These "pig in the poke" clauses are unconscionable, and KMA will develop a public and legislative campaign to outlaw the "all or nothing" or "take it or leave it" contracts. As most of you know, this is primarily an issue brought in by an out-of-state insurance company. We have been pleased that employers are offering employees options to this insurer, so those patients can maintain long-standing relationships with their physician.

● INDEPENDENT EXTERNAL REVIEW

Senator Bob Jackson (D) Murray has introduced BR 74, which mandates an Independent External Review. This legislation will assure that patients and providers will get a fair and final hearing when claims or services are rejected, delayed, or ignored. Like similar patient protections, we believe this legislation will be extremely popular to the public and state legislators. We applaud Senator Jackson for his foresight and concern for patient care.

● UNIVERSAL VACCINE

In accordance with House of Delegate directives, we are working with Governor Paul Patton, Secretary of the Cabinet for Health Services John Morse, and Public Health Commissioner Rice Leach MD, to make Kentucky the 16th "universal vaccine" state. If we are able to attain the necessary funding of approximately \$1.5 million, it will assure that every Kentucky child will be immunized for specific diseases as required by the law.

● TOBACCO SETTLEMENT

We have established a KMA Ad Hoc Committee, chaired by President-Elect Harry W. Carloss MD, to make recommendations to the 1999 House of Delegates to address the expected \$128 million dollar annual payment to Kentucky to settle the tobacco lawsuit. The Committee is considering several recom-

mendations including expansion of Medicaid, funding for the uninsured and uninsurable, tobacco prevention, cessation and education programs, agriculture transition for tobacco farmers, medical research, early childhood development, and public health.

● COMPLEMENTARY AND ALTERNATIVE THERAPY

The KMA has recently completed a survey of over 2000 primary physicians exploring their position and attitude toward Complementary and Alternative Therapy (CAT). The special Task Force established by the Kentucky General Assembly is completing its study. The KMA will present the survey results on June 25 along with its recommendations for the 2000 Kentucky General Assembly.

In addition to these issues, we plan to present legislation relating to the enforcement of late payment statutes; several public health and safety issues; tort reform; further refinement of patient protection; and support for promoting organ donation.

On the regulatory front, we have been dealing with issues including the Coronary Care Networks proposed by Anthem but opposed by KMA in their present format. Officers and staff have been dealing extensively with the Patient Protection regulations and with the Guaranteed Acceptance programs for the "uninsurable." In addition, we held meetings with the Department of Insurance to alleviate the "all or nothing" or "take it or leave it" clauses in one managed care contract. Regulations relating to Certificate of Need, Medicaid managed care, school health, safety, sports medicine, education, Board of Medical Licensure, and physician assistants have all drawn our attention.

These are just a few of the ongoing activities in the legislative and regulatory arena. In the meantime, over 30 outstanding KMA Committees meet on a regular basis to establish policy and deal with patient and professional issues of importance. Their work goes a long way to enhance the profession and this Association's image. Finally, we want to recognize the outstanding work of the various County Medical Societies who work day in and day out in their local communities to address important social and professional concerns. We are appreciative of their outstanding accomplishments.

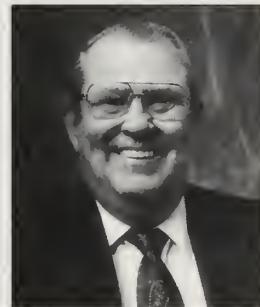
So my friends, these are just a few things we have done for you "lately."

Donald R. Stephens, MD
KMA President

MONITORING Medicine

NEWS FOR KENTUCKY PHYSICIANS

National Legislative Report *Donald C. Barton, MD, Chair*



Effective August 1, 1999, physicians were no longer required to pay the provider tax. The 1996 repeal of the \$44 million annual provider tax was brought about by a massive public, legal, and legislative campaign by KMA.

On June 8 and 9, a delegation from the Kentucky Medical Association visited the Kentucky Congressional Delegation in Washington. The KMA Delegation included Donald C. Barton MD, Corbin, Chair of the KMA National Legislative Committee, William P. Vonderhaar MD, Louisville, J. Gregory Cooper MD, Cynthiana, Andrew R. Pulito MD, Lexington, William B. Monnig MD, Edgewood, and John E. Downing MD, Bowling Green. On June 8, the delegation visited AMA Headquarters for a briefing from AMA lobbyists. The highlight of the trip was lunch and a legislative update with Congressman Ernie Fletcher MD and his staff. Following that meeting we met with Senator McConnell's staff and with Senator Jim Bunning. On June 9 we visited Congressmen Ed Whitfield, Ron Lewis, Anne Northup, Ken Lucas, and Hal Rogers.

The KMA group concentrated on the following issues.

- Patient Protection

- Antitrust Relief for Physicians
- Fraud and Abuse Reforms
- Medical Necessity Definition
- Privacy of Medical Records

Patient Protection

- Independent External Review and appropriate appeals process
- Definition of, and who determines "medical necessity"
- Emergency services provisions
- Comprehensive ban on gag clauses and gag practices
- Patient access to pediatric, obstetrical, and other specialist care
- Requiring health plans to be accountable for demonstrated injury or death resulting from their negligent medical decision-making
- Permit stronger patient protections passed by states to remain in force
- Point of service option

Antitrust Relief for Physicians

We strongly supported "The Quality Health-Care Coalition Act of 1999" (H.R. 1304). The bill corrects the imbalance in power

MONITORING Medicine

by allowing groups of physicians to engage in joint negotiations with health plans. Physicians could agree not to contract individually with a health plan unless a satisfactory contract is negotiated with that plan by the group. This would allow physicians to act as a check on unrestrained health plan leverage. We are pleased that both **Congressman Fletcher and Congressman Whitfield** have signed on as co-sponsors.

Fraud and Abuse Reforms

We believe that fraudulent behavior has no place in the practice of medicine, and in no way do we condone fraudulent activities by physicians. However, the fraud and abuse mantra is attached to almost every administration or congressional initiative that saves money for Medicare. We asked our delegation's support for the following provisions.

- HCFA should not create the payment error prevention program (PEPP) as part of the peer review organizations (PROs)
- HCFA should not encourage carriers to ask physicians to waive their rights to appeal during post-payment audits
- Physicians should have an administrative right of action against carriers who make errors that significantly harm physicians

Medical Necessity

The KMA urged support for legislation that incorporates the following principles: Prudent physicians must be able to make

medical necessity decisions for their patient, without unreasonable interference from health plans for insurers.

KMA Medical Necessity Definition

- Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site, and duration; and (3) not primarily for the convenience of the patient, physician, or other health care provider.
- Patients should not be treated unfairly by health plans or insurers, by denying coverage for medically necessary treatment, based on information the plan or insurer obtains only later in the course of treatment.
- Medical necessity should be determined according to a "prudent layperson standard," which legally and medically is an objective standard—not subject to the abuse that is often alleged or asserted by plans and insurers. Assertions that "medical necessity" standards would lead to requiring insurers to pay for health clubs is a "red herring."

Privacy of Medical Records

- We advocated the basic right of patients to privacy of their medical information and their right to control access to this infor-

mation with narrowly drawn exceptions made in the public interest. We supported the following changes to S. 578 which is presently being considered by the Senate Health, Education, Labor and Pensions Committee, which is addressing privacy of medical records.

- That legislation presently establishes a federal "ceiling" approach to preemption, which would supercede even more protective state law. We support a federal "floor" in establishing standards for protecting patient medical information.
- We opposed a provision that would require a patient to sign a consent form as a condition of enrollment in a health plan or to receive care. How can this be perceived as "consent" if the "consent" is extracted by the threat of not being treated or of one's dependents not having insurance coverage?
- The KMA believes that law enforcement agents should only have access to personally identifiable medical information when acting through a court order or similar instrument obtained under a "clear and convincing" evidentiary standard.

We were extremely impressed with Kentucky Senators' and Congressmen's knowledge of legislation related to patient care and of interest to physicians. All members of KMA are urged to begin writing letters and contacting their Representatives asking support for the above mentioned legislation.

KMA News Review

Below are synopses of news items that have appeared recently in various publications regarding issues of interest to Kentucky physicians.

- The Foundation for Taxpayer and Consumer Rights, a consumer rights group, filed a class action lawsuit against Aetna claiming the company's corporate philosophy changed radically after its merger with U.S. HealthCare. The lawsuit alleges Aetna violated the federal Racketeer Influenced and Corrupt Organizations Act (RICO) by misrepresentations in its marketing and advertising. One of the claims specifically challenges Aetna's right to unilaterally change physician contracts when the company represents that the physicians retain control of medical care. [*Mario v. Aetna, Inc., E.D. Pa., No. 99-CV-1969, filed 4/19/99*]
- A Medicare carrier in Kansas conducted prepayment reviews in which individual physicians were told to submit information on as many as 200 claims. After intervention by the AMA, the carrier announced it would request information on no more than 15 claims. [*AMNews*]
- HMO failures are on the rise. Four of them failed last year, double the number from 1997. Most HMOs are losing money, leaving many patients without coverage. HMO premiums are up while profits are down, which puts the industry on the defensive. According to one expert, HMOs have "saved consumers just about as much money as is possible." [*Life Association News*]
- MedCath Incorporated, a company that focuses on caring for cardiac patients, continues to expand despite opposition. The company's facilities focus on cardiac care and have local physicians as investors. Some argue MedCath's facilities, known as "heart hospitals," siphon off lucrative paying patients and leave other more traditional hospitals weakened in the process. MedCath counters that their facilities provide better care at lower costs because they are narrowly focused in the procedures they perform. The company has plans to continue expanding across the country. [*AMNews*]
- Health plans have contracted with large numbers of physicians so enrollees will not have to change physicians. But the plans may be trying to intentionally drop physicians from their networks to get rid of high-utilizers. They do this by blaming physicians, keeping patients enrolled in their networks long enough to foster loyalty to the plan, and by destroying the physician-patient relationship by forcing physicians to spend less time with their patients. If health plans are able to limit their networks of physicians, they will keep physicians who play by the health plan's rules, which could in turn allow them to offer more cost-effective networks to employers. [*Health Care Strategic Management*]
- Managed care companies' leverage over physicians and medical providers may be diminishing as more providers resist demands for lower rates. The inability to demand lower rates could lead to a company's credit rating being lowered, so many managed care companies are looking for other ways to cut costs. [*Healthcare Financial Management*]
- To reduce the amount of money spent on drugs, many managed care companies are no longer covering such popular drugs as Prozac, Lipitor, Prilosec, and Zocor. Some companies, including Aetna, go so far as to call physicians and ask them to prescribe lowest cost drugs. [*Courier-Journal*]
- Prudential HealthCare recently announced a mandatory program in which physicians are being told their hospital patients will be cared for by a physician whose exclusive job is to care for patients in the hospital. Such physicians are known as "hospitalists." Many physicians are opposed to the program citing their physician/patient relationships, experience in a local hospital setting, and fear of turning over patients to an unknown physician. Twenty-three national and specialty medical societies have protested Prudential's new policy. [*AMNews*]

COVER STORY

Lexington



Nestled in the heart of central Kentucky's famed "Bluegrass Region," Lexington offers an appealing site for the 1999 KMA Annual Meeting, to be held September 27-30 at the spacious Hyatt Regency/Lexington Convention Center. Conveniently located in downtown Lexington, the Center is connected by a covered walkway system to restaurants, shopping, and other hotels. For your convenience, a preliminary schedule of Annual Meeting events will be coming your way in the August issue of The Journal. Take advantage of this opportunity to plan your meeting itinerary and to pencil in a few hours to relax and explore this lively, hospitable region of our state. Following are a few highlights of this picturesque area.

“Heart of the Bluegrass” Hosts 1999 KMA Annual Meeting

Lexington is a highly progressive, innovative, thriving city where hospitality is a word that still has meaning—where you can play on a championship-caliber golf course for about half the greens fee you’d expect to pay—where most attractions are just a breezy 10 to 20-minute drive from downtown!

Settled in 1775, and known as the “Athens of the West” in the early 1800s, Lexington includes many fine historic homes and buildings. Visitors can tour Waveland, a restored Southern plantation built by a relative of Daniel Boone; Ashland, the estate of 18th-century statesman Henry Clay; the Mary Todd Lincoln House, the girlhood home of Abraham Lincoln’s “First Lady”; and the Hunt-Morgan House, the restored Federal-style home of Confederate General John Hunt Morgan. Downtown’s Gratz Park historic district faces Transylvania University, the oldest university west of the Alleghenies.

Lexington’s full arts and entertainment calendar includes theater, the Lexington Philharmonic, and the Lexington Ballet. At night, the city comes alive with music, comedy, and much more.

Outdoor and family activities also abound in Lexington. Golfers can tackle challenging championship courses, such as the Pete Dye-designed Kearney Hill Links. Designated as the “children’s theatre of Kentucky,” the Lexington Children’s Theatre offers world premiere shows and educational theatre as weekend entertainment for the whole family. The Lexington Children’s Museum, housed in a restored 19th century commercial building, entertains youngsters

with interactive exhibits and activities relating to science, nature, and history.

No family stay in Lexington would be complete without spending a day at the Kentucky Horse Park, the world’s only park devoted to the horse. The 1,000 acre working farm and educational theme park is home to representatives of dozens of popular and rare horse breeds, from cute miniatures to giant, yet gentle, draft horses. Include a visit to Keeneland Race Course and Red Mile Harness Track. With its tranquil setting and lovely stone fences and buildings, Keeneland, a national historic landmark, is one of the most genteel and beautiful racetracks in the world. Red Mile is Lexington’s oldest existing racetrack, dating to 1875, as well as one of the nation’s most respected harness tracks.

Within a short drive of Lexington are such attractions as Shaker Village of Pleasant Hill, the nation’s largest restored Shaker Community; bourbon distilleries; pioneer forts; historic railways; Kentucky’s state capital; and Berea, “Kentucky’s crafts capital.”

Meander through the back roads surrounding Lexington where sites border on the dramatic: grazing and galloping horses, lush meadows and extravagant barns, miles of pristine white or historic stone fences. The 450 horse farms in and around Lexington represent both a deep-seated tradition and a thriving modern industry. This multi-county region is truly beautiful and speaks to a slower-paced, bygone era.

Come to your Annual Meeting prepared not only to study and learn, but to tour, to relax, and to enjoy the “Heart of the Bluegrass.”



HEALTH CARE ALTERNATIVES

KMA Annual Meeting
Sept 27 - 30
Hyatt Regency/Lexington Center
Lexington, Kentucky

Watch for next month's *Journal* —
the Annual Meeting Issue of
The Journal of the Kentucky Medical Association!

The Annual Meeting issue of the *Journal* will feature a complete Preliminary Program of events, profiles of KMA officers and guest speakers, synopses of exhibitors, a pull-out travel map, and many other highlights of this not-to-be-missed event!

COMPUTED TOMOGRAPHY GUIDANCE IN BONE MARROW ASPIRATION FOR DIAGNOSIS OF MARROW NECROSIS AND METASTASIS

Tsung-Yao Huang, MD; James T. Huang, MD; Lung T. Yam, MD; Gregory C. Postel, MD; Magdy Abaskaron, MD

Bone marrow necrosis is most frequently diagnosed at postmortem examination. Antemortem diagnosis is still uncommon. We illustrate four cases where initial bedside attempts at needle aspiration and biopsy of primary and metastatic tumor tissue from the sternum were complicated by inadequate specimen retrieval secondary to marrow necrosis and/or tissue destruction by tumor. In these cases, CT guidance was useful in the precise localization of the bulk of the tissue mass and consequently the successful retrieval of adequate diagnostic specimens. We demonstrate CT guidance as an excellent and convenient alternative in circumstances where adequate marrow aspirations and biopsies are difficult and complicated.

Computed Tomography (CT) is used to guide precise fine needle aspiration and biopsy at many tissue sites. However, CT is used sparingly in bone marrow aspiration and biopsy due to the easy bedside accessibility of obtaining such tissues for diagnostic purposes. We have found CT guidance to be useful in lesions of marrow necrosis and metastasis where precise localization of the aspiration and biopsy site was necessary to retrieve adequate diagnostic tissue, as the following cases illustrate.

PATIENTS AND METHODS

The patients were studied by CT, in the supine position, with arms raised above their heads. Contiguous 3mm thick sections were obtained from the sternal notch through the manubrium, body, and xyphoid. All CT scans were obtained

on Picker International 1200SX with 512 matrix, 44cm field size and 3mm thickness. Scans were magnified two fold and viewed at 700-900H window and at about between -20 and -30 H level. The site of maximal sternal abnormality containing a soft tissue mass in the marrow was identified. With the use of the standard CT guide lights, the skin correlating to the mass was marked and prepared in the usual sterilized technique. One percent Xylocaine local anesthesia was given. Needle puncture was performed and confirmed by CT. Adequate specimens were also confirmed by Cytologist and collected for further study.

Case 1

This 62-year-old white gentleman was first seen 4 years ago with a chief complaint of sternal pain for 2 months. He was found to have hypercalcemia, monoclonal IgG spike, and multiple lytic bone lesions. A sternal marrow aspirate showed 90% plasma cells. A diagnosis of multiple myeloma was established. The patient improved following treatment with melphalan and prednisone.

He was doing well until 1 year ago when he again began to notice sternal pain. Several bedside sternal aspirations attempted at the site of maximal tenderness either failed to obtain

From the Department of Diagnostic Radiology (Drs TY Huang, Postel, Abaskaron), University of Louisville School of Medicine, Louisville, KY; Veterans Administration Medical Center, (Dr Yam, Chief of Hematology), Louisville, KY; and University of South Florida (JT Huang, resident), Tampa, FL.

COMPUTED TOMOGRAPHY GUIDANCE IN BONE MARROW ASPIRATION FOR DIAGNOSIS OF MARROW NECROSIS AND METASTASIS

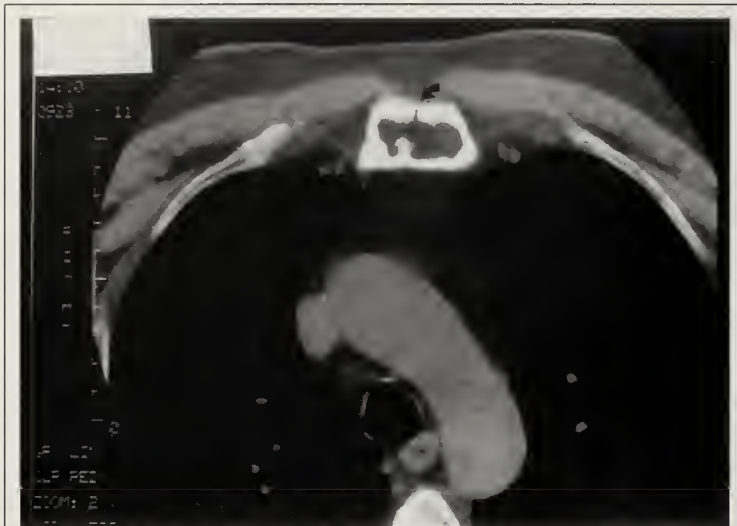


Figure 1A. CT of sternum revealed empty marrow without soft tissue mass on previous puncture site (arrow).

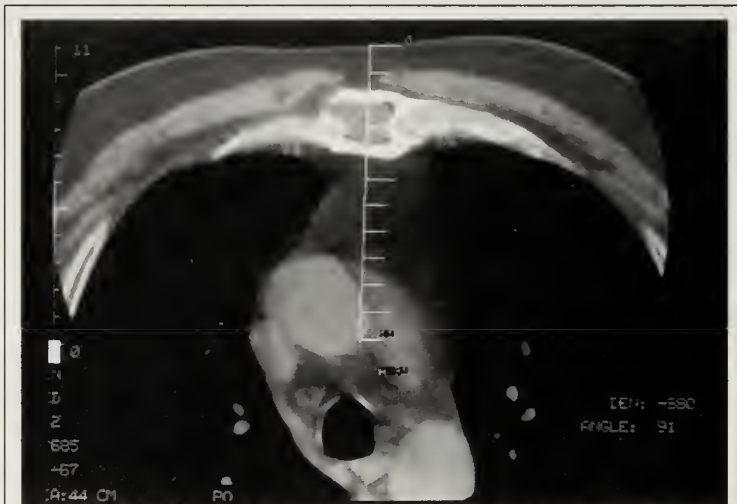


Figure 1B. CT of sternum lower level demonstrating soft tissue mass within the marrow. Biopsy was performed which showed marrow necrosis and the presence of over 90% myeloma cells.

adequate specimens or obtained specimens with many normal hemopoietic cells and no plasma cells. Repeat Ig and Beta microglobulin were elevated. CT of the initial bedside sternal aspiration site revealed fat density without a soft tissue mass (Figure 1A). Subsequently, CT was used to identify the site of maximal sternal abnormality containing a soft tissue mass in the marrow (Figure 1B). A site on the skin correlat-

ing to the mass identified by CT was marked, and an aspirate was obtained which showed marrow necrosis and presence of over 90% myeloma cells. The patient was treated with chemotherapy and the sternal pain subsided.

Recently, the sternal pain and tenderness recurred. CT of the sternum revealed diffuse involvement. He was treated with radiation therapy to the whole sternal area and has remained free of sternal tenderness and pain.

Case 2

This 60-year-old white gentleman with a history of extensive pulmonary disease and an 80+ pack year history of cigarette smoking, was 5 years status-post diagnosis of Stage B transitional cell carcinoma of the bladder with radical cystectomy and radiation therapy. He presented this time with complaints of chest pain and cough with blood-tinged sputum. Chest films revealed a right upper lobe lung nodule and multiple costal and sternal lesions. CT of the chest and abdomen demonstrated a right upper lobe lung nodule, a soft tissue mass with destruction in the sternum, and a right renal mass. Using CT guidance, fine needle aspirations of the sternal mass (Figure 2) and the right renal mass were performed. The right upper lobe nodule biopsy was not done because of high risk of pneumothorax. Pathology findings confirmed the diagnosis of transitional cell carcinoma with metastasis in both biopsy specimens. The patient underwent chemotherapy with methotrexate, velban, adriamycin, and cisplatin, and tolerated the chemotherapy well without complications.

Case 3

This 62-year-old black gentleman sought medical attention because of severe low back pain, chest pain, and symptoms of prostatism. Pertinent physical findings included pallor, cachexia, tenderness over the posterior iliac crest and sternum, and a large nodular prostate. Laboratory findings included a complete blood count with leukocyte count of 3700/mm³, hemoglo-

bin of 8.2 g/dl with microcytic hypochromic anemia, platelet count of 197,000/mm³, and immature granulocytes and erythroblasts were seen. Serum acid phosphatase activity was increased. Bone scan showed multiple areas of increased uptake. A biopsy of the prostate revealed adenocarcinoma.

The clinical suspicion of cancer involvement of the sternum and iliac crest with marrow necrosis was supported by a Tc99 radionuclide scan. However, several bedside attempts at marrow aspiration from the sternum and the posterior iliac crest yielded scanty amounts of bloody fluids containing tissue debris and a few normal hemopoietic cells. A CT of the sternum localized a soft tissue mass density within the marrow and an adequate marrow biopsy of the mass confirmed the diagnosis of metastatic prostatic carcinoma and marrow necrosis.

Case 4

This patient is a 60-year-old black gentleman who was hospitalized for assessment of progressive lower extremity weakness and fecal and urinary incontinence. A chest roentgenogram showed a left upper lobe lesion, hilar adenopathy and multiple lytic lesions in the ribs and vertebra. A myelogram demonstrated complete block at T7. The iliac crest aspiration and biopsy at bedside showed hypercellularity, but no malignant cells. Sternal marrow aspirations were performed at bedside, but with some difficulty. The aspirates were small samples of bloody fluid containing tissue debris, a few viable cells and rare clumps of malignant cells. Finally, CT of the sternum was performed and the areas of tissue destruction were localized. The skin was marked, and subsequent biopsies taken were shown to be consistent with poorly differentiated adenocarcinoma of the lung with metastasis.

RESULTS

In case one, the scans showed multiple irregular low attenuation destructive lesions in the manubrium and upper body of the sternum.

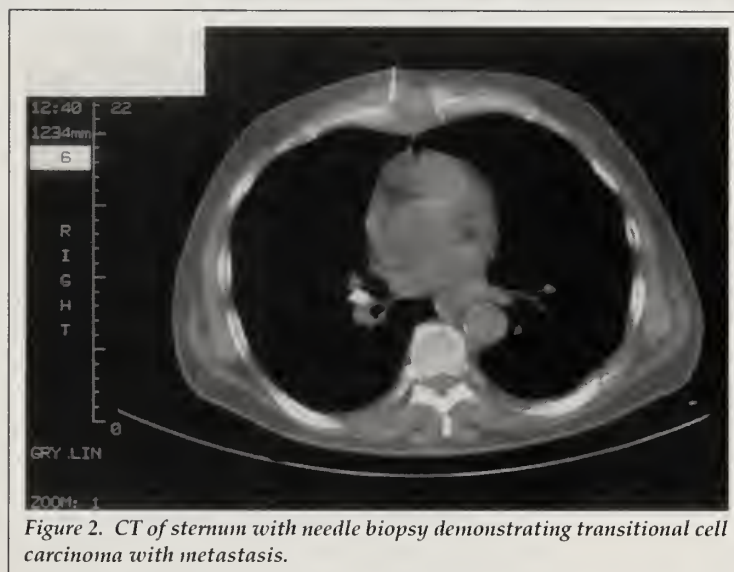


Figure 2. CT of sternum with needle biopsy demonstrating transitional cell carcinoma with metastasis.

The previous bedside puncture site was noted on the low density area, and the soft tissue mass density in the lower body of the sternum was identified. With the use of the standard CT guide lights, an indelible mark was made on the patient's skin over the site to be biopsied. The aspirates obtained revealed marrow necrosis and the presence of over 90% myeloma cells.

In cases two, three, and four, the scans of the sternum disclosed irregular mottled destructive lesions. The skin was also marked by using the CT guide lights. The sternal aspirations were performed and proven to contain tumor metastasis.

Computed tomography guidance in bone marrow aspiration and biopsy was performed on a total of seven patients in our experience. All seven patients had different malignant processes including: carcinoma of the prostate with sternal metastasis and marrow necrosis, multiple myeloma of the sternum with marrow necrosis, carcinoma of the breast with sternal metastasis and marrow necrosis, carcinoma of the colon with sternal metastasis and marrow necrosis; and metastases from carcinoma of the lung, transitional cell carcinoma of the bladder, and a carcinoma of unknown origin. Four patients had associated marrow necrosis.

DISCUSSION

The merits of Computed Tomography (CT) guided percutaneous needle aspiration and biopsy of lesions throughout the body are well documented in the literature.¹⁻⁸ CT is invaluable in directing the needle to a small lesion, detecting the extension of tumor for biopsy, and avoiding overlying bony structures. In addition to detecting and localizing lesions, CT provides very precise localization of the needle tip, and helps avoid the necrotic center, both of which are important in the biopsy success.

Bone marrow necrosis is an uncommon condition often associated with malignancies, marrow disorders, sepsis and bone pain. Patients with these conditions often have anemia, leukopenia, thrombocytopenia, leukoerythroblastosis and may require frequent transfusions to maintain a stable hemoglobin level. The marrow of such patients is frequently difficult to obtain by aspiration or biopsy. Microscopic examination of the specimen invariably demonstrates few viable cells and much tissue debris on marrow aspirates and extensive marrow necrosis on marrow biopsies.^{9,10} However, the extent of marrow involvement may be assessed by radionuclide scan of the bone marrow and Magnetic Resonance Imaging.^{11,12}

Our study showed that CT scan of the bone marrow can either predict or confirm the site of marrow involvement. In general, the CT appearance of the normal sternum is characterized by sharp cortical margins, distinct corticomedullary interfaces, and peristernal soft tissues clearly delineated by fat. A thorough knowledge to recognize the important normal sternal variants is essential, which include: cortical unsharpness along the posterior aspect of the manubrium, lateral surfaces of the body, and at the sternal fibrocartilaginous articulations; soft tissue prominence at the junction of the sternum and costochondral cartilage; and bony sclerosis at the transitions from manubrium to body and from body to xiphoid. The medullary cavity when infiltrated with tumor has a positive CT number, therefore CT imaging can be used to determine the extent of primary and metastatic tumor infiltration of the bone marrow.

In case one, the patient presented with chest pain and sternal tenderness while his myeloma was judged clinically stable. It was both frustrating and puzzling upon repeated failure of adequate bedside marrow aspiration until CT guided aspiration revealed and localized myeloma and necrosis in the marrow. In cases two, three, and four, the CT guided sternal marrow aspiration and biopsy helped obtain specimens to strengthen the clinical finding of tumor metastasis and marrow necrosis.

In conclusion, CT is an excellent and convenient tool for guiding all types of skeletal biopsies and aspirations. Precise localization of the site of the biopsy and the tip of the needle are possible, as well as to allow accurate placement of the biopsy needle. Computed Tomography guidance is an alternative, as well, in circumstances where adequate aspirations and biopsies are difficult or complicated.

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BRUCE A. SCOTT, MD YOUNG PHYSICIANS DESIGNATED POSITION, AMA BOARD OF TRUSTEES

Four KMA members serve in elected leadership roles in the American Medical Association. For a relatively small delegation of five Delegates and five Alternate Delegates, that is a significant accomplishment.

To inform you, our members, on what is taking place on your behalf at the AMA, The Journal is publishing interviews about the involvement, thoughts, and observations of these four leaders—"The AMA Connection."

This month we complete the interviews with a profile of Bruce A. Scott, MD, Young Physicians Designated Position, AMA Board of Trustees. The series began in April with a profile of Robert R. Goodin, MD, Member, AMA Council on Medical Education; May profiled Ardis D. Hoven, MD, Council on Medical Service; and the June issue profiled William B. Monnig, MD, Secretary, Governing Council, Organized Medical Staff Section.

JKMA: Please give our readers a brief history of the Young Physicians Designated Position on the AMA Board of Trustees.

Dr Scott: The American Medical Association Board of Trustees had traditionally consisted of 15 members elected at large among practicing physicians, academic physicians, administrative physicians, and other physicians representing different groups within the AMA's House of Delegates. A number of years ago they added a seat for a student and



then a second seat for a resident physician to represent those unique sub-areas of the continuum of the practice of medicine. In 1995, the House of Delegates recognized the importance of the young physician population—the population of physicians under age 40—and felt this was a unique perspective that needed to be represented at the level of the Board of Trustees. The Bylaws were amended to create a specific seat for a physician under age 40. The position is a full voting member of the Board of Trustees. The physician is elected by the House of Delegates, and once elected, actually represents all physicians and speaks as do other members of the Board of Trustees for the physicians of America, not just young physicians.

JKMA: What is the main mission/area of responsibility of the AMA Board of Trustees?

Dr Scott: The core purpose of the American Medical Association is to promote the art and science of medicine and the betterment of public health. The Board of Trustees has oversight responsibility of the affairs of the Association. Working with the House of Delegates, Councils, Sections, and senior staff, the AMA Board of Trustees defines the vision of the future of the Association, then begins to implement a strategic plan. The Board of Trustees specifically has the fiduciary responsibility for the organization, and legally the Board is charged with the responsibility to oversee the fiscal welfare of the Association. The Board of Trustees also gives a voice to the concerns raised by the House of Delegates, whether speaking before medical or non-medical groups, government agencies, or government hearings. We also represent the House of Delegates and the Association's concerns through the legal system when necessary. Overall we carry out the agenda established by the House of Delegates.

JKMA: What is your major goal as a member of the Board of Trustees?

Dr Scott: It is to provide the perspective of young physicians on

issues that come before the Board; but, more generally, to make the AMA a recognized essential part of every physician's professional life. We need to be relevant to individual physicians and their individual practice of medicine. We need to reconnect with membership, and we need to communicate exactly what it is that we do that makes us essential to the individual practicing physician.

JKMA: *What issues are you dealing with?*

Dr Scott: The AMA Board of Trustees carries on the advocacy work of physicians in Washington, DC, ranging from the Patients' Bill of Rights to our response to the challenges of Medicare payment and Medicare fraud and abuse; HCFA's payment updates; the definition of medical necessity in legislation that is pending; public health standards and criteria that we help to set in Washington, DC; then coming down to the individual practice of medicine and private sector advocacy activities in responding to the challenges of managed care organizations and health plans, contracting for health care, and managed care contracting.

The AMA is also the world's largest medical publisher. Along with the other credentialing and standard-setting bodies, we set the standards for both graduate medical education and continuing medical education. We support the ethical code that has been the basis of the AMA for over 150 years. So the bottom line is that the AMA is entrenched in just about every issue that affects the practice of medicine in the United States.

JKMA: *What is the greatest strength of the Young Physicians group?*

Dr Scott: The greatest strength, I think, is the fresh perspective that young physicians provide. The young physician group in the 11 years of its existence has never been afraid to question the norm and challenge the way things have been. Young physicians today are more diverse than physicians have ever been in the past. I mean that in terms of their ethnicity, their gender, and the modes of practice which they are choosing. Young physicians today are more likely to be employed, they are more likely to be practicing in large groups, and this diversity is expressed in a variety of issues and the variety of ways in which they look at issues. It has been said that if you always do things the way you have always done things, then you always get what you have always gotten. The Young Physicians Section is willing to try a new way when necessary.

We are obviously most concerned with issues that affect going into practice, contracting for joining a group. But then young physicians are also involved in issues that will affect the future of medicine. We are more involved than some of the other groups in electronic communications, electronic prescribing, and the effect of the Internet on the future practice of medicine. And finally, the unique perspective we



have is that each time we examine a change that is about to occur in medicine, whether that is a contract we have been handed to potentially sign for individual practice, to a change that congress is about to make, we have to look at that change from a perspective of, what is this going to do to the practice of medicine; not tomorrow or next year, but 10 or 15 or 20 years from now to see exactly what effect that is going to have on *our* patients and practices.

JKMA: *What area of this group needs more effort?*

Dr Scott: Membership clearly is the issue that needs more effort. Young physicians as a group are simply not joiners, and I don't mean just medical associations. The demographics of the group of individuals below age 40 in America show that they simply don't join organizations. Even though our practices today are more challenged by the changes in reimbursement and the infringement upon the autonomy of the practice of medicine than physicians ever have been in the

past, young physicians are not finding the value in membership. That is something we have to change. I think it is a factor of not communicating adequately to young physicians exactly what we do. And perhaps it is not enough of a response to the challenge of representing young physicians in those different modes of practice and the diversity that we spoke of earlier. Maybe the old way of representing people isn't adequate anymore.

JKMA: *AMA membership in Kentucky continues to be stable, although AMA membership has been declining over the past few years, nationally. Why, in your opinion, should physicians support the AMA?*

Dr Scott: The AMA is the *only organization* that represents and speaks for all physicians and their patients nationwide. As the practice of medicine changes more and more with electronic communications and the Internet, the geographic boundaries of where you practice seem to mean less. Never before has there been more of a need for a national organization. A lot of times the way I phrase it to physicians when I am talking to them about membership and what does the AMA do for me, is in the form of questions. "If not the AMA, then who? If the AMA had not stood up when HCFA and AARP instituted a plan to have senior citizens turn in their physicians for fraud, who would have been there? If the AMA did not challenge the merger of Aetna and Prudential, who would have? If the AMA wasn't there responding to the health insurance industry's activities in

Washington, DC, and supporting the Patients Bill of Rights, who would be there?" Many people would respond, "Well, there are always the specialty associations." The problem is that each specialty association comes to the table with a slightly different bias. Because of that, when the people in Washington hear multiple and different answers, they can simply pick and choose which answer it is that fits them at the moment, and in the end physicians gain nothing.

One of the best things about having an organization that provides a national perspective is that individual physicians and individual communities do not need to repeat history. We can learn from the activities that have occurred elsewhere. That is true in terms of medical education; that is true in terms of credentialing; and very importantly, that is true with health plan contracting. The AMA can provide a national perspective as to what is happening elsewhere so that individual medical communities are not alone to respond to different challenges of the daily practice of medicine.

The problem is as membership declines and the AMA represents a lower percentage of American physicians, our advocacy will be diminished. There will be no one else there to fill the void. I can think of nothing worse than the physician's voice being silenced—the patient's greatest advocate being silenced. That's why each physician in America needs to reexamine whether it is worth slightly more than one dollar a day for them to have an organization that will protect their profession.

JKMA: *What do you see as the greatest impediment to AMA membership?*

Dr Scott: The greatest impediment is a lack of awareness of the advocacy that we provide, which has inestimable value. We see that in poll after poll of our members and of nonmembers, and unfortunately, you get the advocacy whether you pay your membership dues or not. When the AMA goes to Washington and represents physicians, the positive effects of physicians not having to pay one dollar every time they submit a Medicare claim form are spread among all physicians. When the AMA is successful in getting a major managed care organization to change the unacceptable provisions in a contract, all physicians who are signing the contract, not just members, get the benefits. When the American Medical Association is able to maintain high standards of medical education and begin to deal with issues facing the work force of the future of medicine, all physicians benefit, not just the members.

JKMA: *The AMA House of Delegates made some significant changes in the structure and governance of the AMA. Can you describe some of these changes and how they will affect the membership and the operation of the AMA?*

Dr Scott: The goals of the committee that studies the structure and function of the AMA were very laudable. It's too early to see what will happen; the changes are being implemented as we speak, and it is an ongoing process. If the end result is that we become more responsive to our members and



more in touch with the grass roots, then it will be a wonderful thing that has happened for the AMA. At this time, I just think it is too early to tell. Certainly every organization needs to step back and examine itself and evaluate where we are at any given time and figure out where we need to be.

JKMA: *What is the most critical issue facing the AMA? What should be done or is being done about it?*

Dr Scott: Membership is the most critical issue, but having already spoken about that, I'll speak to what I believe is the most critical issue facing the profession rather than our professional organization.

The most critical issue facing the profession is the daily challenge to the autonomy of the practice of medicine—the challenge to the sacred trust that is the patient/physician relationship, which has been the core of what has made American medicine great for many years, and the core on which the AMA was built 151 years ago. The challenge begins all the way at the beginning of education and continues in daily practice. There is a

group of individuals who would bring an international medical school onto the shores of the United States to provide unaccredited medical education. There are challenges daily to the medical licensure and the scope of practice of physicians. Other groups are vying to be able to do what physicians have traditionally done.

There are those in Washington who would have the patients and the senior citizens of the United States believe that their physicians have a motivation other than the patient's best interests and would ask them to report their physicians, or to "drop a dime" on their doctor.

We believe that is not the right answer. The answer to the hundred thousand pages of rules that the federal government has come up with is to simplify them, to clarify them, then to educate the physicians. The vast majority of physicians want to comply, if we can simply understand exactly what it is the government wants us to do. But even more onerous is the daily infringement upon the practice of medicine by other individuals who have motives that economically are very clear. You begin to fear that there are health plans that are placing the fiscal health of their bottom line ahead of the medical health of our patients. It is simply unacceptable that a health plan can *deny care* and not be held accountable for that, yet physicians *providing care* are held to the highest standards of accountability that our nation knows.

JKMA: *In what area does the AMA need to expend more effort?*

Dr Scott: The area of electronic communication and the Internet is a booming industry, and all predictions are that it will expand more and more into the daily activities of the United States, with more individuals logging on everyday. The AMA needs to increase our examination of the electronic media; ranging everywhere from patients receiving information from the Internet, physicians prescribing over the Internet, to psychiatrists doing counseling sessions over the Internet.

What does this mean to the practice of medicine? Certainly there are some wonderful things that can be gained through the electronic communications media, and certainly there are some very scary things that we are beginning to hear about. We need to be proactive in this media to make sure we are on the cutting edge. That's an area we need to delve deeper into than we have.

JKMA: *What changes or new directions would you like to see occur for the AMA?*

Dr Scott: The AMA is already changing. The AMA is having a more active role in the daily practice life of physicians. I've heard it said, "This is not your father's AMA anymore." The AMA is moving in directions in aggressive advocacy that many have said they have not seen before. Currently, we are in the process of appealing to the Department of Justice to try to stop the merger of a major health plan with another. We have engaged health plans in active debate

on contract provisions affecting the daily practice of health care. We have had health plans come to us and ask us what provisions do we like in health plans and what would a desirable contract look like. We are considering taking legal action against the federal government, HCFA, to get rightful payment for physicians that is owed them from the changes in sustainable growth rate calculations. This is an aggressive stance that I believe is the new AMA.

JKMA: *Patient Protection was the primary legislative goal of AMA in 1998. While congress failed to enact patient protection reforms in 1998, what is the outlook in 1999? What other AMA legislative goals are we seeking in Washington, DC?*

Dr Scott: The Patient Bill of Rights or the Patient Protection Act has certainly seen a large amount of activity both on the federal and state level. Many states have enacted on a state level some component of the Patient Bill of Rights or the Patient Protection Act. There are many different bills before the House and the Senate this year. We don't believe this needs to be a partisan issue, that the Democrats are right or the Republicans are right. There are many different bills that have components we like.

The bottom line for the American Medical Association is that any bill that is passed has to have four key components. I call those:

First—*The right to know*, which is basically the end to secrecy. Patients have the right to know what is in their health plan, exactly what it is they are buying. Physicians have the right to know the

rules. There should be no black boxes. Physicians can only obey the rules if they know the rules.

Second—*The right to hear*. There should be no gag clauses. Physicians should be able to freely communicate with their patients those issues they believe are of concern to the patients, right here, right now.

Third—*The right to emergency care*. If a prudent lay person believes an emergency exists and they go to the emergency room, then the insurance company should compensate that service. Interesting to know, this was actually wording that originated from a resolution from the Young Physicians Section in the AMA.

Fourth—*The right to accountability*. We believe physicians and patients have to have the right to appeal a decision that they disagree with to an independent, external panel of experts that are adequately trained in the area of expertise that the question is being framed in, and the decision must be binding.

Those are the four key necessary components of any bill that is passed.

Right now the debate in Washington seems to be centering around the issue of determining medical necessity. Health plans have figured out that the definition of medical necessity may be the most important part of the Patients Bill of Rights. The AMA believes it should basically be a prudent physician standard. It should be



within the accepted standards of care. Some health plans would include a provision that medical necessity is, quote, "the least expensive of the alternatives available," unquote. We believe that is simply unacceptable. In the end, we ask, "Who do you want determining what is appropriate medical care for your mother—a bureaucrat basing this upon his bottom line, or your mother's physician?"

In addition to that, in a different area of concern to the American Medical Association is the Campbell Bill, which is House Bill 1304. The Campbell Bill would allow self-employed physicians the ability to collectively negotiate with health plans and insurers. This basically provides much needed anti-trust relief for individual physicians. The anti-trust laws in America were written to protect the buyers of services, but have been interpreted to protect the large insurance companies and health plans who in effect purchase medical services from independent practitioners. There is no question where the true power rests, when

a major health plan can control thousands and thousands of lives and a large percentage of physicians' practices, versus an independent practitioner who wants to be able to simply negotiate reasonable health contract provisions in a plan.

JKMA: *What do you see as the greatest strength of the AMA?*

Dr Scott: The greatest strength may also be our greatest weakness. The AMA is the most democratic organization I have ever seen in my life. Any individual member can bring an issue before the House of Delegates and that issue will be heard. It will be debated, and a decision will be made. The AMA is called upon to represent all physicians, but on many issues there is conflict and disagreement, so there is no way we can make everybody happy all of the time. Our studies show that people quit their membership over issues that they disagree with, but they don't join over issues that they agree with. Therein lie both our greatest strength and our greatest weakness.

JKMA: *On a more personal note, what is your perspective on the time commitment that it takes for young physicians to be involved with AMA, considering that many are building*

careers, have busy practices, young families, etc?

Dr Scott: That's a great question. There is an incredible time commitment that is necessary to be involved in organized medicine, particularly at the level of the Board of Trustees. I think it is important to say up front—patients continue to always come first. I actively practice medicine. My peers on the Board of Trustees are also physicians, so they understand that in each of our practices the patients always come first.

It does demand a certain level of patience on the part of my referring physicians, on the part of my staff, and particularly on the part of my partners. Our group recognized that this would be a challenge to the group as I accepted the responsibility of this new position. My partners have been willing to pick up that extra burden, and I thank them for that. But, probably the greatest impact has been on my personal time. You just don't have a lot of idle time when you have three children below age eight, yet I try to do everything I can to remain active in their lives. There is no way I could do this without the support of my wife, Christy, who also recognizes the importance of the American Medical

Association's activities. She has supported me from the very beginning and in each of the individual steps I have taken to reach this level of involvement.

I recognize this is a once-in-a-lifetime opportunity for personal growth and personal experience. To be one of four physicians from Kentucky since 1847 to ever serve on the Board of Trustees; to be one of the only individuals from my specialty to ever serve on the Board of Trustees; and to have an opportunity to impact American medicine and the care of patients in America like I have the opportunity to do, is something to which you just can't say "No." I thrive on being informed and being part of driving change. Those who know me will tell you that I have never been a person who sits by and lets things happen to me. The more that I am challenged, the more that I do. I believe in the AMA, and I hope that the long-term benefits of what I am able to accomplish for the practice of medicine and for my patients will outweigh the short-term loss. But, there is no doubt that there is a real challenge to the day-to-day time commitment that is necessary.

Interview and photos by Sue Tharp, Managing Editor, JKMA.

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REPORT ON THE DOCTOR SMOKESTOPPER PROJECT

A Public Health Collaboration by the Kentucky Medical Association, Kentucky Division of Substance Abuse, Kentucky Regional Prevention Centers, and the Kentucky Department of Public Health

This report is based on brief interviews with 630 primary care physicians in 86 Kentucky counties during September-November 1998. The 630 physicians constitute about 30% of Kentucky's estimated 2,129 primary care physicians (2,129 is a refined total count of primary care physicians practicing in January 1998).

At best, the data produced by these structured interviews represent Kentucky's primary care physicians at a 95% level of confidence, plus or minus 3.3%. Confidence levels are lower for certain questions that received smaller responses. The generally high responses and resulting high confidence level for most questions make it possible to draw some conclusions and useful inferences.

BACKGROUND

In early 1998, discussions were undertaken between the state Division of Substance Abuse and the Kentucky Medical Association on the prospect of jointly sponsoring a campaign to promote anti-tobacco preventive health messages to the patients of primary care physicians in Kentucky. Two KMA committees heard reports from the Division using findings published in *American Medical News*:

- Half of all Americans who ever smoked have quit, but 50 million still smoke.
- If doctors advised each

smoking patient to quit, 1.7 million more would quit each year.

- Quit rates rise 7-10% where patients are asked and counseled routinely about smoking.
- On average, only 2% of all physician office visits include smoking-cessation advice.

The Doctor SmokeStopper project was approved to proceed with intent to "systematically approach every primary care physician in the state to ascertain whether they consistently offer anti-tobacco advice to patients, encouraging all physicians to adopt or maintain at minimum a common simple procedure:

1. Ask every adult and adolescent patient if s/he smokes or uses tobacco in any form.
2. Where affirmative, advise the patient to stop smoking and/or using tobacco.
3. Where negative, reinforce the wisdom of that choice."

Project participation was expanded to include representatives of the state Department of Public Health and from Regional Prevention Centers, the substance prevention arm of Community Mental Health Centers across the state. Endorsement was obtained from major organizations concerned with the impact of tobacco on health.

METHODOLOGY

- Volunteers in each county, trained and supervised by

Regional Prevention Centers, scheduled brief appointments with all primary care physicians. Volunteers were instructed to keep visits to the point, deliver the message and take no more than five minutes. If a question arose concerning tobacco counseling beyond the recommended brief inquiry and advice, volunteers were instructed to support physician discretion.

- Physician contacts were quantified, recording the percent who already give anti-tobacco patient advice and the percent who agreed to adopt the recommendations of this project. Questionnaires with checkoff answers were employed to ensure simplicity of administration by the volunteer interviewers. With Yes/No representing the most probable answers, an alternative "other" answer was available for each question.
- Each physician was offered useful handouts (appended at end of this report) which included 1) 100 copies of a 1-page handout suitable for both adult and adolescent patients; and 2) a 1-page quick reference sheet giving the physician information on where to obtain more patient handouts, and some facts on the beneficial effect of routine physician inquiry and advice concerning tobacco use.
- Data were collected in 86 counties, well distributed geographically across the state,

representing 13 of the 15 regions covered by the Regional Prevention Centers.

SUMMARY OF FINDINGS

This survey indicates that a preponderant majority of Kentucky primary care physicians use their influence to promote patient health concerning use of tobacco. More than four-fifths (84%) of those interviewed say they routinely ask all adult patients if they smoke or use tobacco. A somewhat smaller majority (73%) ask the same question of adolescent patients, the age group most prone to experimentation and initial addiction. Over three-fourths of these physicians

routinely commend patients who say they don't use tobacco, and virtually all (97%) say they advise quitting to patients who admit smoking or using tobacco.

Among this majority who ask patient status, a minority indicated they are less than "routine" in commending abstainers and advising users to quit. Most of these physicians responded affirmatively when asked if they "will now start" doing these things. The "Yes" response was especially high (93%) by those agreeing to now start advising adolescent smokers to quit. It thus may be inferred that being asked these questions, during this survey, had a salutary effect on these physicians' intentions to

become more proactive concerning tobacco and patient health.

Comparable inference of the survey's beneficial impact may be drawn from the fairly small minority of physicians who reported they do not ask—routinely or at all—"every" patient whether he/she smokes or uses tobacco. Among this minority, 72% stated their agreement "to now start" routinely asking tobacco-related status of every adult and adolescent patient. Most of these physicians also agreed to start commending patients who say they don't use tobacco, and to advise quitting to patients who admit smoking or using tobacco.

You Can Quit Smoking

Nicotine: A Powerful Addiction

If you have tried to quit smoking, you know how hard it can be. That is because nicotine is a very addictive drug.

Quitting is hard. Usually people make 2 to 3 tries, or more, before finally being able to quit. Studies have shown that each time you try to quit, you will be stronger and will have learned more about what helps and what hurts. This handout tells about how you can improve your chances of quitting smoking and overcome your addiction to nicotine.

Three Methods For Becoming a Nonsmoker

Experts say three methods work. You have the best chance of quitting if you use them together:

- ✓ Use the nicotine patch or gum
- ✓ Get support and encouragement
- ✓ Learn how to handle urges to smoke

① Use the Nicotine Patch or Nicotine Gum

The patch and gum help lessen the urge to smoke. The nicotine in the patch and gum passes through the skin. This reduces the craving for nicotine when you stop smoking. It is important to follow the directions carefully when using the patch or gum. Ask your health care provider for advice or read the information in the package.

While you may still get cravings to smoke, don't smoke while using the patch or gum!

Who should use the nicotine patch or nicotine gum?

Research shows that almost everyone can benefit from using the patch or gum.

If you are pregnant or have heart or blood vessel problems, your health care provider will be especially careful about giving you the patch or gum.

How do I know what strength is right for me?

The patch: Most smokers should start using a full strength patch (15-22 mg of nicotine) daily for 4 weeks and then use a weaker patch for another 4 weeks (5-12mg of nicotine).

The gum: Many smokers should start using the 2-mg dose. However, you may want to use the 4 mg gum if you:

- ✓ Smoke more than 20 cigarettes a day.
- ✓ Smoke as soon as you wake up in the morning.
- ✓ Have tried and failed to quit on a lower dose.

If you are a very light smoker (less than 10-15 cigarettes a day) or have health problems, a health care provider can help you select the right dose.

How do I get the nicotine replacement products?

The patch and the gum are available without a doctor's prescription. To be safe, carefully read and follow directions inside the package. Talk with your doctor now about nicotine replacement products!

If you have any side effects from the patch or gum, be sure to tell your health care provider right away.

② Get Support And Encouragement

Counseling can help you learn how to live life as a nonsmoker. Brief counseling or advice from your health care provider can help. Also, you may want to join a quit smoking program. Studies of people who have quit show the more counseling you have the greater your chance for success.

A quit smoking program should last for at least 2 weeks with 4-7 sessions that are 20-30 minutes long.

③ Learn How to Handle Urges to Smoke

Be aware of things that may cause you to want to smoke. Avoid difficult situations while you are trying to quit. Try to lower your stress level. Take time to do things you enjoy. Exercise can also help.

Special Care Required

Pregnant women/new mothers: Smoking puts your baby at risk for sudden infant death syndrome (SIDS), poor lung development, asthma, and infections.

Hospitalized patients: Smoking slows recovery from illness and surgery. It slows bone and wound healing. Most hospitals don't allow smoking.

Heart attack patients: Second heart attacks are more common in people who continue to smoke.

Lung, head, and neck cancer patients: Smoking can cause a second cancer, even after successful treatment.

Healthy and Smoke Free

Smoking isn't cool or smart... ...It's addictive and deadly.

Health problems

Smoking can cause some immediate health problems such as coughing, shortness of breath, bronchitis, loss of stamina, frequent colds, and high blood pressure.

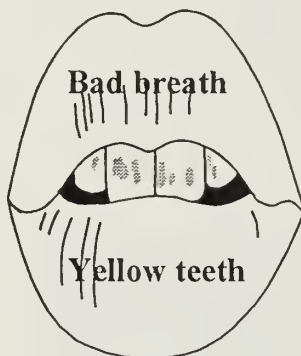
Money problems

Cigarettes can cost you hundreds or thousands of dollars a year. Think of all that you could do with that extra money.



Looking bad

Smoking makes you look and smell bad. Your teeth and fingernails may have a yellowish stain. Your skin may become leathery and your breath, hair, clothes and car will reek of smoke.



Tobacco ads are everywhere!

You'll find them on billboards, magazines, movies, videos, clothing. This doesn't mean smoking is cool. It means cigarette companies want you to think it's cool. These ads don't show people getting sick, with yellow teeth and wrinkled skin, or coughing.

Nicotine

Cigarette contain nicotine which is the drug that gets teenagers "hooked" on tobacco. Cigarette smoke also contains



- Carbon monoxide-car exhaust
- Formaldehyde-used to preserve dead animals
- Ammonia-toilet bowl cleaner
- Cyanide-Rat poison

MYTH:
Smoking won't kill me

FACT: It could. 1 out of every 3 young people who start smoking will eventually die from a related condition.

Be Smoke Free

If you don't smoke, Congratulations! Your health, appearance, and friends must be important to you. Resist any pressure to start. Help others by warning them of the dangers of tobacco smoke.

If you do smoke, you can quit! Thousands of people do it every day. Talk to your doctor about the best method for quitting.

Stay Smoke Free

Printed with funding from the Substance Abuse Prevention and Treatment Block Grant

Doctor Smokestopper -- PHYSICIAN FACT SHEET

A Tobacco Use Reduction Project of the Cabinet for Health Services

(Division of Substance Abuse and Department of Public Health)

In Conjunction With and Endorsed By the Kentucky Medical Association

Dear Doctor: You have the potential for great influence against the nation's foremost preventable cause of death and illness. We urge you to use your influence.

American Medical News, the AMA weekly newspaper, stated in a July 21, 1997 article by Michael Fiore, MD, that doctors across America are neglecting to treat the biggest health risk now facing their patients -- tobacco addiction. This disease will kill almost half the people it afflicts, often after years of suffering, but it also is a disease we can cure. The article states:

Unfortunately, there's a good chance physicians do not even know whether a patient is a smoker. The reason is simple: Nobody asked.

This article and more recent issues of *American Medical News* highlight physicians' potential for reducing the epidemic of health problems caused by tobacco use:

- **On average, only 2% of physician office visits include smoking cessation advice.**
- **Just as effective treatment of hypertension depended on the inclusion of blood pressure as a vital sign, effective treatment of smoking warrants the same priority in our day-to-day practice.**
- **Most current data show that quit rates rise from 7% to about 10% in practices where patients are asked and counseled routinely about smoking. This need not be terribly elaborate and can take as little as three minutes per visit to still be effective.**
- **Projected onto a national scale, if every clinician asked every patient on every visit about tobacco use, it could mean another 2 million people kicking the habit each year (a study published in the Dec. 3, 1997 *Journal of the American Medical Association* concluded that if doctors advised each of their patients who smoked to quit, an additional 1.7 million would quit each year).**
- **Half of all Americans who ever smoked have quit. Though another 50 million continue to light up, surveys show almost 70% of smokers want to quit. The risk that physicians face is giving up too quickly when they don't see results. Oftentimes, physicians, by providing support and giving information, are setting the stage for change even though they may not see the end result.**

Kentucky leads the nation in tobacco use. One of every three Kentucky adults and nearly 50% of our children and youth are regular cigarette smokers; adolescent use of smokeless tobacco and cigars is sharply rising. (U.S. Centers for Disease Control; National Institute for Drug Abuse)

Studies show that physicians can routinely assess tobacco use and provide effective cessation advice in less than two minutes -- significantly increasing the likelihood that patients will quit. Success rates double for patients assisted with medications such as nicotine gum and patches.

-- see over --

To address the problem of nicotine addiction, we encourage you to adopt Smoking Cessation Clinical Practice Guidelines issued by the U.S. Agency for Health Care Policy and Research (AHCPR). These Guidelines are very straightforward and easy to implement in clinical settings. The **Doctor Smokestopper** project addresses two of the guidelines:

- ✓ Asking every patient if they use tobacco products at every clinic/office visit.
- ✓ Informing every tobacco user about the health risks and advising them to quit.

We encourage you to routinely employ these AHCPR Guidelines with every patient regardless of age, gender, educational level, health status, number of cigarettes smoked per day, or readiness to quit.

TOBACCO INFORMATION FOR PATIENTS

HANDOUT: the Doctor Smokestopper project offers you 100 copies of a 1-page information sheet you may give to patients, that they may be better informed about the harmful effects of tobacco and how to become tobacco free. One side is designed for adult readers, the other side for youths -- both sides contain useful information for all ages. You are invited to make as many more copies of this handout as you wish.

REGIONAL PREVENTION CENTERS: These centers, attached to Community Mental Health Centers throughout the state, work on the community level to combat use and abuse of alcohol, tobacco, illegal drugs and other substances. In addition to consultation and technical assistance with community substance prevention projects, they offer a variety of brochures and other materials on the risks of using tobacco and other substances.

The Regional Prevention Center in your area may be reached at 800/432-9337.

AHCPR: The Agency for Health Care Policy and Research offers a variety of useful materials for both clinicians and patients (available for a small fee), as well as their recently-launched "Two-Three Initiative" that encourages all clinicians to take part in helping their patients who smoke to quit. The following can be viewed on AHCPR's Web site at <http://www.ahcpr.gov/>.

- Smoking Cessation. Clinical Practice Guideline no. 18.
- Helping Smokers Quit: A Guide for Primary Care Physicians.
- Smoking Cessation: Quick-Reference Guide for Smoking Cessation Specialists.
- Smoking Cessation: A Systems Approach.
- You Can Quit Smoking: Consumer Guide.

Other Kentucky Organizations Supporting Reduction of Tobacco Use:

- Kentucky Medical Association Alliance (state headquarters 502/426-6200).
- Local health departments (health educators; adult health team members).
- Kentucky ACTION (state headquarters 877/KY4-KIDS).
- American Heart Association, Ohio Valley (formerly AHA, Kentucky Affiliate).
Louisville 502/587-8641; Lexington 606/278-1632.
- American Cancer Society, Midsouth Division.
Louisville 502/584-6782; Lexington 606/276-3223.
- American Lung Association of Kentucky.
Louisville 800/LUNG-USA; Lexington 606/276-4344.
- Kentucky Nurses Association (state headquarters 502/637-2546).
- Kentucky Parent-Teachers Association (PTA) (state headquarters 502/564-4378).



Jaroslav P. Stulc, MD

AN ECONOMICS COURSE IN MEDICAL SCHOOL?

I recently gave a presentation on Career Day to the senior class of our local high school regarding becoming a physician. I came fully prepared with anatomical models and surgical instruments, ready to knock students out of their collective socks. I practically stood on my head to gain their attention; I bent over backwards, I bent over forwards. Nothing roused them from their adolescent torpor—only the teacher and the kid with the pocket protector seemingly appreciative. When I asked for questions, one student leaning on an elbow languidly raised her hand. “Yeah,” she asked, “when we gonna learn somethin’ we can use?”

The laudable pursuit and love of knowledge for its own sake, no matter how commendable, in retrospect is truly a self-indulgent luxury. There are only so many heartbeats in a lifetime, so brief a time, so few chances, and so much to learn in order to survive. Graduate school, such as medical school, demands the acquisition of prodigious amounts of factual material, not only to master the fundamentals of the discipline, but in order to allow the student to pass Board exams in a timely fashion. It is problematic, however, how much of that which is retained promulgates a better physician or has any

substantial application to the real world of medical practice. Please do not misunderstand me. A thorough knowledge of the principles is essential in order to produce a critically thinking physician capable of abstract problem solving and management. For instance, I completely endorse chanting in classes for medical students or the ability to calculate the pulmonary ventilation/perfusion ratios in a man standing on his head on the planet Xanax. A day doesn’t go by when I don’t contemplate K1 and velocity equations for allosteric enzymes or recite mantra like the sedimentation coefficients of ribosomal subunits for the welfare of my patients. I hardly disdain the arcane or the esoteric; I embrace it. My immunology thesis, for instance, was on the differentiation of anti-idiotypic murine T-helper cells, and I can recite scads of trivia, such as the exact dates of both defenestrations of Prague (even the third, if you count that one). Arguably, however, all this does not translate into a more proficient physician. Furthermore, it hardly prepares you for Real Life outside the Ivory Tower.

My point is this: granted that our professional education requires us to cram a quadrillion isolated facts into our small

Graduate school, such as medical school, demands the acquisition of prodigious amounts of factual material . . . It is problematic, however, how much of that which is retained promulgates a better physician or has any substantial application to the world of medical practice.

craniums, in the hope that enough of those retained will eventually allow for analytical thought and the occasional original insight. With the requirements for absorbing the information explosion, incorporating progressively abstract concepts and yet becoming ever more attuned as graduate students to compelling needs for understanding moral ethics, sex education, computer systems, and the like, why not offer a course the students can really use, a basic course in economics. Devise a course given in the last year or two, without testing, that would cover introductory business principles, professional and personal money

At what point in time do we have the opportunity to learn to navigate the maelstroms of the business world?

management, retirement investing, practice start up, and so forth. My students and residents regularly turn their noses up at articles I glean for them from the medical literature, but give them a review paper on introductory economics or investing and I can't hit the print button on the Xerox® fast enough.

My arguments for an economics education for our students have come from hard won lessons appreciated and garnered only later in life and after many financially costly mistakes. I have seen my colleagues and my own, hard-

earned retirement investments, chiefly through imprudent decisions, go flatter than Marlon Brando sitting on a paper cup. And no wonder. At what point in time do we have the opportunity to learn to navigate the maelstroms of the business world? As a group, physicians are generally considered to be intelligent, industrious, and responsible, but absolute morons when it comes to substantial business decisions. We were predominantly science majors in premed, perhaps a smattering of English or History majors, but virtually never Economics or Business majors, nor did we want to be business people. By the time we graduated from medical school, many of us were fortunate to be able to balance our checkbook. But in short order, we were called upon to manage school loan debts, family finances, mortgages, and professional contracts, followed in rapid succession with establishing and managing an office or academics department, grant monies, negotiating partnerships,

insurance company and government contracts, understanding private and government health care mumbo jumbo and fret over retirement investing, assuming we'd never see a social security sawbuck. The argument could be forwarded that any number of other subjects of marginal interest would, therefore, be valid for inclusion into the medical curriculum, such as scuba diving or Nineteenth Century Samoan literature. However, no other valid topic such as the Basics of Economics would be as pragmatic or gird as well the common Achilles' heel of the nascent physicians. With a prioritized economics course, the average graduate would hopefully be expected to distinguish the NASDAQ from the Amtrak® or Hemovac® and an IPO from the PLO or NPO, initiating the first steps towards fiscal maturity, responsibility, and independence—"learning something we can actually use."

Jaroslav P. Stulc, MD

ALTERNATIVE MEDICINE

To the Editor:

Everyone is talking about alternative medicine, holistic medicine and herbal remedies. They are the hottest thing around—the new kid on the block. Wrong. MDs practicing traditional medicine are the new kid on the block. Our profession was born again in 1910 with the Flexner Report. That was when we closed the diploma mills, adopted the scientific method, began good research and firmed up the tradition of medical ethics.

Before that, what we now call alternative medicine was the only medicine. There were no standards of medical education, no proper research, no licensing or certification as we know it. Except for laxatives the only

effective drugs were opium, quinine and mercury. The FDA was not created until 1938.

We are seeing a ground swell of interest in returning to the dark ages of alternative medicine. Many of our otherwise enlightened patients are rushing to embrace this quasi science based on anecdotal evidence, folklore and obsession with natural products.

The mission of alternative medicine is PREVENTION. Their mantra is: How much better to prevent disease than to have to treat it after it develops. Who could disagree with that? But the truth is none of us are very good at prevention except for a few examples such as Pap smears and immunizations.

Heaven knows, we in tradi-

tional medicine have our shortcomings and gaps of knowledge. We have been accused of being crisis oriented. We are guilty; so are soldiers and fire fighters. They and we are skilled at fighting wars, putting out fires and treating you when you are sick. We are hardly if any better than anyone else at teaching you how to prevent wars or house fires or disease.

There is plenty of room for both our medicine and their medicine, but like oil and water they don't mix. These people are not like us. I say more power to them, but don't join them until they bring themselves up to present day standards.

Jack C. Keeley, MD
Owensboro, KY



PRECISION
STAFFING, INC.

Precision Staffing is the premier staffing agency in Kentucky. We have recently expanded into the Louisville area. Below is a sample of some of the positions we are filling:

- Medical Recruiter: Staffing company specializing in medical office industry. Interview, screen, and represent applicants to clients. Salary + bonus and benefits. Exceptional growth opportunity. 4-year degree, medical experience and five years work experience.
- Medical Transcriptionist: Fast paced outpatient care facility offering, great benefits, clothing allowance, free parking. Great opportunity!
- Medical Records Clerk: East end location—fast paced, friendly environment. Great opportunity and benefits!
- Medical Assistant: Plush medical office in the east end. Benefits include 401-K, health insurance, and performance bonuses.

Please contact Paula or Heather at **454-4900** if you are interested in a medical/clerical job and we will be glad to assist you in finding the perfect fit for you. *Never a fee.*



Carolyn Daley

LITERACY AND HEALTH

The developmental process can be greatly enhanced by being read to at an early age. The Kentucky Medical Association Alliance is promoting literacy and reading to young children. We hope that the love of learning will encourage young people to develop their full potential in life as opposed to developing unhealthy lifestyles. The KMA Alliance is promoting a program called Reach Out and Read (ROR), which was developed at the Boston Medical Center in 1989 by pediatricians and early childhood educators. The Reach Out and Read Program is available to all pediatricians and family care providers. Kentucky currently has five Reach Out and Read programs. Reach Out and Read is a program that includes literacy as an integral part of pediatric care. Information about Reach Out and Read may be obtained from the KMA Alliance office or from the Boston Medical Center. The Internet Home Page address is www.reachoutandread.org. An application for a start-up grant may be obtained from the Reach Out and Read Home Page on the Internet. Included with this article are brief highlights of the ROR Program and a "Prescription for Reading."

The President of the Kentucky Chapter of the American Academy of Pediatrics, Tom Young, MD, FAAP, Lexington, enthusi-

astically endorses this program, and I quote a few of his comments:

Medical research continues to demonstrate the critical importance of sensory experience in early brain development. The structure of the developing brain is determined by the nurturing and experiences provided. Children's ability to read and learn has been shown to be related to early and consistent exposure to being talked and read to. An innovative program called "Reach out and Read" (ROR) provides the opportunity for physicians to

encourage optimal early brain development. ROR provides new developmentally appropriate books at each preventative well child exam. Volunteers model reading in the waiting room and physicians observe development of the child as the child interacts with the book. KMAA should be applauded for its efforts to expand this program throughout Kentucky. Physicians, parents, and children all win with this program.

Carolyn B. Daley
KMAA President

PRESCRIPTION FOR READING

Date _____

Child's Name _____

What to do:

Share a Book with Your Child

- ☐ Every night at bedtime
- ☐ For _____ minutes every day

Other Ideas: _____

Signature _____



Printed with generous support from
Cordelia Corporation
Pritzker Cousins Foundation

REACH OUT AND READ (ROR)

THE PROBLEM

- **Children who live in print-rich environments and are read to in their preschool years** are much more likely to learn to read on schedule
- **Parents of children living in poverty may lack the money to buy books**, may not have easy access to good children's books, and may not themselves have been read to as children
- **Reading problems may mean school failure**, which increases the risk of absenteeism, dropping out, juvenile delinquency, substance abuse, and teenage pregnancy—all of which perpetuate the cycles of poverty and dependency

PROGRAM DESCRIPTION

- Reach Out and Read is a program that **makes early literacy part of pediatric primary care**
- **Pediatricians encourage parents to read aloud** to their young children and **give their patients books to take home** at all pediatric check-ups from six months to five years of age
- Through Reach Out and Read, **every child starts school with a home library** of at least ten beautiful children's books, and parents understand that reading aloud is the most important thing they can do to help their children learn to love books and to start school ready to learn

HOW ROR WORKS—PROGRAM COMPONENTS

- Volunteer readers in the clinic waiting room **read aloud to children as they wait for their appointments**, showing parents and children the pleasures and techniques of looking at books with children
- **Pediatricians are trained to counsel parents** about the importance of reading with young children, offering age-appropriate tips and encouragement
- **The doctor gives the child a new developmentally and culturally appropriate children's book to take home and keep at every check-up from six months to five years of age**

PROGRAM BACKGROUND

- **Reach Out and Read** was developed at Boston City Hospital (now **Boston Medical Center**) in 1989 by a collaboration of pediatricians and early childhood educators
- The **ROR National Center** based at Boston Medical Center makes start-up grants to sites throughout the country. Awards include training for medical staff, administrators, and start-up book grants.
- The National Center provides ongoing technical support for sites including training materials, a book ordering system and fundraising advice, as well as communication vehicles linking sites to the National Center and each other (website, listserv, newsletter). The Center also provides national leadership for public policy and legislative change to bring literary resources to our target population.

For more information:

Please contact the Reach Out and Read office by phone (617) 414-5701 or fax (617) 414-7557 or write to the Reach Out and Read National Center, Boston Medical Center, One BMC Place, 5th Floor High Rise, Boston, MA 02118.

NEWSMAKERS

Jack L. Hamman, MD, FACS, of Madisonville, and **Gregory L. Stevens, MD, FACS**, of Louisville, recently received 3-year appointments as the Cancer Liaison Physician for the Hospital Cancer Program at Trover Foundation Regional Medical Center and Baptist Hospital East, respectively. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons.

Drs Hamman and Stevens, who have a significant interest in the diagnosis and treatment of patients with malignant diseases, provide leadership to the cancer committee at their appointed institutions in order to maintain their Commission-approved cancer program, or assist them in seeking approval as a new program. They also provide community leadership by volunteering at the division or unit level of the American Cancer Society.

In recognition of his lifetime commitment of service to the neurosurgical community, his patients and the commonwealth of Kentucky, **Russell L. Travis, MD**, of Lexington, was recently honored by the US House of Representatives. Dr Travis is the Immediate Past President of the American Association of Neurological Surgeons (AANS)—one of the largest neurosurgical associations in the world with more than 5,300 members from over 30 countries.

For the past 25 years, Dr Travis has responded to the

neurosurgical needs of the commonwealth of Kentucky by traveling hundreds of miles to see patients in towns where you wouldn't normally find a neurosurgeon—towns like Whitesburg and Hazard, where adequate medical attention is in short supply. In addition, he has been instrumental in forming the Kentucky Physicians Care Program—a nationally recognized volunteer program that provides free medical care to the uninsured and underinsured of Kentucky.

Patrick J. Serey, MD, an orthopedic surgeon in Morehead, recently became the first University of Kentucky College of Medicine graduate to have two children who also received medical degrees at UK. Dr Serey was one of 30 members of the first-ever UK medical school class, in 1964; son **Thomas J. Serey, MD**, a Danville urologist, graduated in 1992; and son **Kevin Serey, MD**, was a member of the 1999 class.

Frank C. Miller, MD, a professor at the University of Kentucky College of Medicine, was recently installed as President of the American College of Obstetricians and Gynecologists at the 38,000-member organization's annual meeting in Philadelphia.

Dr Miller has a list of goals he wants the organization to pursue, including a top priority of doing more to boost women's health care nationally and to work with other medical groups to achieve universal health coverage for women.

Dr Miller recently stepped down as chairman of obstetrics and gynecology at UK, although he continues to teach at the College of Medicine.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

ADAIR

Jennifer L Friend MD FP
PO Box 480
Columbia 42728
1986, U of Dominica, Ross U

BARREN

Jeffrey C Sabolovic MD OBG
301 Professional Park Dr
Glasgow 42141
1994, U of Texas, Houston

CHRISTIAN

Stephen P Schroering MD ORS
1717 High St, Suite 2D
Hopkinsville 42240
1985, U of Louisville

DAVIESS

Lynette K Martin MD PD
2211 Mayfair Ave #106
Owensboro 42301
1991, Northwestern U

FAYETTE

Gary T Cannon MD FP
100 Eastside Dr Ste 2
Georgetown 40324
1985, UTESA, Dominican Republic

- John Samuel Davis MD** PTH
135 E Maxwell St Ste 401
Lexington 40508
1988, Med Coll of Georgia
- Henry J Iwinski MD** ORS
489 Seeley Dr
Lexington 40502-2614
1985, Brown U, Providence
- Arun Kadambi MD** PD
2370 Nicholasville Rd Ste 102
Lexington 40503
1985, B J Med Coll, India
- Bradley B Keller MD** PD
UKMC Room MN-472
Lexington 40536
1985, Pennsylvania St, Hershey
- Hatim A Omar MD** PD
1188 Baker Ln
Nicholasville 40356
1985, High Inst, Sofia, Bulgaria
- Daniel P Reese MD** AN
3124 Weymouth Ct
Lexington 40509
1986, U of Arkansas, Little Rock
- Eric Ruschman MD** EM
3460 Castleton Hill
Lexington 40503
1991, U of Kentucky
- HARDIN**
- Roger K Allen MD** D
Ste A Christopher Square
Radcliff 40160
1970, Wayne State, Detroit
- JEFFERSON**
- Geetha Bhat MD** C
530 S Jackson St
Louisville 40292
1980, U of Cincinnati
- Alfred L Chatman MD** P
1169 Eastern Pkwy
Louisville 40217
1964, Meharry Med Coll, Nashville
- Beverly Dilworth MD** IM
210 E Gray St Ste 1005
Louisville 40202
1995, U of Louisville
- Anthony K Duncan MD** R
1224 Spring St Ste 2
Jeffersonville 47130
1976, U of Louisville
- Shaheen M Gill MD** PD
1400 LaFontenay Ct
Louisville 40223
1981, Fatima Jinnah Coll, India
- Jeffrey Ray Graves MD** AN
8208 Regency Woods Way
Louisville 40220
1987, U of Louisville
- Todd Milton Hobbs MD** FP
10216 Taylorsville Rd Ste 400
Louisville 40299
1995, U of Louisville
- Roger Scott Hoffman MD** OPH
4004 Dupont Cir Ste 1
Louisville 40207
1993, U of Kentucky
- Joel A Kaplan MD** AN
323 E Chestnut St
Louisville 40202
1968, Jefferson Med Coll
- Rima Mounla MD** PD
5010 Wolfpen Woods Dr
Prospect 40059-9196
1990, Aleppo U, Syria
- Sean Chevalier Owens MD** R
3930 Dupont Circle
Louisville 40207
1993, U of Tennessee, Memphis
- Lawrence H Peters MD** AN
908 Albermarle Ct
Louisville 40222-5601
1990, Royal Coll of Surg, Ireland
- Richard M Pokorny MD** S
900 Lake Forest Pkwy
Louisville 40245
1992, U of Louisville
- Deborah L Quinton MD** P
1919 State St Ste 360
New Albany 47150
1994, U of Louisville
- Laleh Rezaei MD** PD
11307 Leesburg Pl
Louisville 40241
1995, U of Louisville
- Frank Tolis Simon MD** A
1404-B Browns Ln
Louisville 40206-0418
1991, U of Kentucky
- Charlotte G Stites MD** PD
2400 Longest Ave
Louisville 40204
1995, U of Kentucky
- John P Sullivan MD** P
1700 Ups Dr Ste 107
Louisville 40223-4026
1980, U of Louisville
- Barbara Ann Troje MD** P
302 Salem Court West
Otisco, IN 47163
1985, U of Kentucky
- Scott A Young MD** IM
212 Prestwick Pl
Louisville 40243
1995, U of Louisville
- KENTON**
- Joseph R Allen MD** FP
10186 Hempsteade Dr
Union 41091
1993, U of Louisville
- MADISON**
- Raza Hashmi MD** C
100 Joshua Circle, Apt 50
Berea 40403
1981, Allama Iqbal Med Coll, Pakistan
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Miriam M Reyes MD	FP
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M D Phelps, Jr, MD

Jamestown, KY

1923-1999

M D Phelps, MD, a retired cardiologist, died March 7, 1999. Dr Phelps was a 1947 graduate of the University of Louisville School of Medicine and a life member of KMA.

Virginia A Stevens, MD

Louisville, KY

1930-1999

Virginia A Stevens, MD, a retired obstetrician and gynecologist, died March 19, 1999. A 1956 graduate of the University of Louisville School of Medicine, Dr Stevens was a life member of KMA.

OBITUARIES

Richard W Gardner, MD

Ashland, KY

1913-1999

Richard Gardner, MD, a retired general practitioner, died February 9, 1999. Dr Gardner was a 1939 graduate of the University of Cincinnati College of Medicine and life member of KMA.

Norman Adair, MD

Covington, KY

1913-1999

Norman Adair, MD, a retired radiologist, died February 26, 1999. A 1941 graduate of the University of Louisville School of Medicine, Dr Adair was a life member of KMA.

Carl E Rutledge, MD

Bowling Green, KY

1928-1999

Carl Rutledge, MD, a retired pathologist, died March 20, 1999. A 1955 graduate of the University of Louisville School of Medicine, Dr Rutledge was a life member of KMA.

Gabe A Payne, MD

Hopkinsville, KY

1918-1999

Gabe A Payne, MD, a retired pediatrician, died April 13, 1999. Dr Payne was a 1943 graduate of the Vanderbilt University School of Medicine and a life member of KMA.



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AMA Gains Victory for Quality Medicine

In a move that benefits patients and reinforces a commitment to quality care, the Department of Veterans Affairs withdrew a proposed rule that would have authorized non-physician health professionals to prescribe medications.

"This is a victory for quality medicine," said AMA Chair **Randolph D. Smoak, Jr, MD**. "Physicians' unique training and expertise make them best suited to determine the appropriate drug therapy for patients. With 11 to 16 years of formal education and training after high school, physicians are prepared to make difficult prescribing decisions, including when medical intervention is appropriate and how to address adverse reactions and other complications."

The VA published the proposed rule in early May, which prompted immediate AMA action. "The proposal is totally inadequate and would subject patients within the VA system to extreme risk," AMA Executive Vice President **E. Ratcliffe Anderson, Jr**, stated in a strongly-worded letter that was hand delivered to Undersecretary for Health for Veterans Affairs, Kenneth Kizer, MD, MPH on May 12.

In addition to potential risks to patients, the AMA stressed the lack of specificity and detail in the proposed rule. "We believe these are serious oversights and strongly urge you immediately withdraw this proposed rule and rewrite it to provide sufficient detailed criteria to insure that patient safety and practice concerns are met," Dr Anderson stated.

Two days after receiving the AMA letter, the VA agreed to withdraw the proposal. "The AMA will remain vigilant to assure that patient safety is paramount when the final rule is issued," Dr Smoak said.

JAMA Editorial Independence Addressed in New Reporting Structure

The AMA recently announced that the next editor of the *Journal of the American Medical Association (JAMA)* will report to a seven-member independent committee on all editorial-related issues.

The announcement included the following information: **Roger N. Rosenberg, MD**, chair of the JAMA Editor Search Committee and editor of the AMA's *Archives of Neurology*, and AMA leaders unveiled a new governance plan for JAMA. The charge given to this committee on January 27 was to review existing practices and develop safeguards that would guarantee JAMA's integrity, editorial independence, and responsibility. In addition, the committee was to determine how the editor's performance can best be measured, and finally, to find a new Editor-in-Chief for JAMA.

The search committee proposed a plan that was approved by the AMA Board of Trustees. Under this plan, a seven-member journal oversight committee will serve to not only evaluate the Editor-In-Chief, but also to provide a buffer between the Editor-in-Chief and AMA management. The search committee believes this system will foster objective consideration of issues that arise

between the journal and its parent body.

The seven-member journal oversight committee will include one member of the AMA senior management, one member from outside the AMA with publishing business experience, and five members representing the scientific, editorial, peer-reviewer, contributor and medical communities. No member of the committee may be an AMA employee except the member from AMA Senior Management. The AMA senior management representative may not serve as Chair of the committee.

Any proposal to dismiss the Editor-In-Chief for any reason shall be brought before the journal oversight committee for evaluation and a formal vote. The recommendations and views of the journal oversight committee shall be presented to the AMA Board along with the recommendations and views of the AMA's Executive Vice President. A two-thirds vote of the AMA Board would be required for dismissal of the Editor-In-Chief.

The Editor-In-Chief will continue to report to the AMA's Senior Vice President for Publishing and Business Services for business and financial operations.

Dr Rosenberg said the search committee is committed to finding an outstanding Editor-in-Chief, and every effort will be made to do so within the next several months. He added: "The new editor will be expected to lead JAMA into the 21st century and to provide the clinical and scientific acumen and vision needed to maintain JAMA's high standard of excellence."

INFORMATION FOR AUTHORS

Manuscripts — Articles will be accepted for consideration with the understanding that they are original and are contributed solely to this *Journal*. The transmittal letter should designate one author as correspondent and include the author's address and telephone number. Receipt of manuscripts will be acknowledged and unused manuscripts returned. All material is reviewed by the Board of Editors and publication of any article is not to be deemed an endorsement of the views expressed therein.

Preparation — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.

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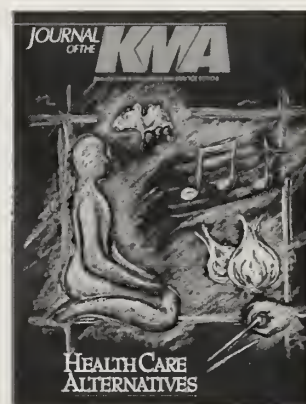
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COVER:

"Health Care Alternatives" is the theme of this year's Annual Meeting, scheduled for September 27-30 at the Hyatt Regency/Lexington Center in Lexington. The 1999 meeting continues KMA's commitment to offering an outstanding educational event featuring numerous sessions on timely medical issues. This month's cover introduces a complete preliminary program for this not-to-be-missed event. You will find in these pages a pull-out section containing an abridged schedule of events and maps for your convenience in locating meeting facilities. Highlight your September calendar for Monday the 27th through Thursday the 30th to attend KMA's Premier educational event!

Design and artwork by Lee Wade of Eminence, Kentucky.

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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Periodical postage paid at Louisville, KY and additional offices. Yearly subscription rates: \$35 domestic; \$45 foreign. Single issues \$4 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222. Telephone 502/426-6200 Fax 502/426-6877 Email member@kyma.org

Listed in *Index Medicus*. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

EDITORIAL AND ADVERTISING: Contact Sue Tharp, JKMA, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222. Phone 502/426-6200; FAX 502/426-6877.

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Printed by the Ovid Bell Press, Inc, Fulton, Missouri 65251.

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LEAD OR FOLLOW

While others may be more highly trained in certain areas, physicians alone, in my opinion, have the global knowledge to determine the future of health care.

Even though there have been many changes in health care, it still remains that our patients and our communities regard us as the most knowledgeable about their health. While others may be more highly trained in certain areas, physicians alone, in my opinion, have the global knowledge to determine the future of health care.

With this knowledge, however, goes the responsibility for us to lead our communities in the right direction. I fear that physicians caught up in curing illness and fighting to survive with managed care are abdicating their role in leadership.

The new wave in most communities is towards the maintenance of health and a healthy life style. We, as physicians, are having trouble getting in step with this idea. My own community has done a report card on its citizens' health and is looking at ways to make improvements. We also have assessed our school children's health and are looking at ways to improve their outcome.

Boards of health in most counties meet very rarely and then only to set tax rates. We must reactivate these boards, appoint physicians to serve who will be active and use them to play a larger role in determining, for example, how the health department will function in the community. While many physicians serve on district boards of health now, it seems

their role is largely to determine how to survive a shrinking budget.

Each development district in Kentucky has a health sub-council charged with developing and setting policy for health-related issues. For many reasons physicians are not serving on these councils as they should.

Schools are looking for physicians to consult on health issues concerning their students. The "adopt-a-doc" program is helping, but we must be available to assist the schools, and in fact, we must assert our influence or accept the consequences of poorly designed health programs in schools.

These are just a few examples of the areas where we as physicians can and must play leadership roles in our communities. Unfortunately, the majority of these positions provide no remuneration and, in fact, cost the respective physician because of time out of the office. Remember, however, if we don't lead, we must follow or get out of the way. It is my hope that we will strengthen our leadership role in each of our communities as it can only help us and our patients in the future. It is also my hope that our medical schools will instill in our young physicians a sense of this responsibility by encouraging them to be involved in their community and exposing them to community health issues.

Donald R. Neel, MD
KMA Vice President

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NEWS FOR KENTUCKY PHYSICIANS

PATIENT PROTECTION LEGISLATION

During the recent US Senate debate over Patient Protection Legislation, Donald C. Barton MD, Chair of the KMA Committee on National Legislation, wrote the following letter to Senator Mitch McConnell and Senator Jim Bunning outlining KMA's position on various aspects of patient protection.

On behalf of the physician and student members of the Kentucky Medical Association (KMA), we are pleased that the Senate has agreed to begin debate on patient protection legislation. Bipartisan enactment of comprehensive legislation in this area is urgently needed.

We understand that the Senate will consider the "Patients' Bill of Rights Act," S 326, as reported by the Committee on Health, Education, Labor and Pensions, as the starting point for debate. We believe that the "Consensus Managed Care Improvement Act of 1999," developed in the House of Representatives by Representatives Tom Coburn and Charles Norwood, serves as an appropriate blueprint for managed care reform. We urge you to consider its provisions as patients' rights legislation moves forward. For purposes of your debate next week, we would like to provide some major points regarding S 326 for your consideration.

GRIEVANCES AND APPEALS

The KMA is pleased that S 326 would create a grievance and appeals system with a binding external appeals mechanism. We support timely, independent, binding review as a method of resolving patients' disputes with health plans. We are concerned, however, that despite inclusion of the term "independent," S 326 does not ensure that the external review entities and reviewers are independent and not beholden to the plans.

We are pleased that the bill does not require prior authorization for the provision of covered emergency services. However, the bill incorporates review and notification timelines for coverage denials involving non-emergent care that would favor the health plans at patients' expense. **External review under S 326 could take up to 65 days**, or even longer if the plan does not submit timely information to the external review entity.

In any appeals process, any review of physician determination must be made only by physicians (medical doctors or doctors of osteopathy) of the same specialty and licensed in the same state as the treating physician. In order to avoid bias, except where the review entity is a state agency, a health plan should not assign more than a certain percentage of its requests for external review to a particular review entity. In addition, the Kentucky Medical Association believes that a review process will not be meaningful without strict timelines that ensure patient appeals are handled in a timely fashion. The Kentucky Medical Association recommends the following timelines:

- Initial determination—no preapproval for emergency care, within 24 hours for urgent care, or within 15 days otherwise.
- Internal Review—within 24 hours for urgent care or within 10 business days otherwise.
- External Review—within 72 hours for urgent care or within 30 days otherwise.

The KMA asks that S 326 be amended to establish fair and equitable grievance and independent appeals procedures in accordance with the above requirements.

MEDICAL NECESSITY

S 326 would permit arbitrary health plan definitions of medical necessity to control all coverage determinations. This bill also would permit plan bureaucrats, rather than properly qualified,

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licensed physicians, to make medical necessity decisions. In addition, there is no assurance in the bill that plan determinations of medical necessity would be based on "generally accepted standards of medical practice."

An essential element of any sound external appeals process is how "medical necessity" will be determined. **The KMA strongly believes that medical necessity should be determined using a prudent physician standard in accordance with generally accepted standards of medical practice.** We are not advocating that every conceivable medical service for every patient in every instance be covered. Nor are we saying that every physician decision be upheld. On the contrary, we are principally concerned that some health plans have sought to manipulate the definition of medical necessity to deny patient care by arbitrarily linking it to lowest cost measures without considering the individual patient's medical condition. Permitting plans and issuers to arbitrarily define medical necessity would continue to lead to abuses that ultimately harm patients.

The Kentucky Medical Association asks that S 326 be amended to require that medical necessity decisions be made in accordance with generally accepted standards of medical practice.

ACCOUNTABILITY

This bill should remedy the inequity that results from health plans' ability to routinely make medical decisions while remaining unaccountable for the injuries they cause. Health plans duplicitously argue that they should make medical necessity decisions and control utilization review and appeals processes while stating that they want to be protected by ERISA preemption. By not removing that immunity, this bill would fail to hold those health plans accountable. Presently, 125 million enrollees participate in ERISA-covered health plans, and despite state legislative initiatives to provide adequate legal remedies, those enrollees are all without effective legal recourse against their health plans. This is an issue of fundamental fairness.

The KMA firmly believes that Americans covered by ERISA plans must have the same right of redress as those who are covered by non-ERISA plans. We therefore request that S 326 be amended to remove ERISA preemption for health plans.

POINT OF SERVICE

All enrollees in managed care plans should be offered a point-of-service option that will enable them to obtain care from physicians outside the health plan's network of participating physicians. We also support provisions to provide increased access to the services of obstetricians/gynecologists and pediatricians.

SCOPE OF PATIENT PROTECTIONS

The Kentucky Medical Association strongly believes that **all** Americans should receive fundamental patient protections. However, as written, S 326 only applies to patients in ERISA plans, and many of the patient protections in the bill only apply to patients in "self-funded" ERISA plans. Therefore, ironically, S 326 does not cover patients most likely to be enrolled in HMOs that employ abusive practices. Approximately 111 million patients will not receive nor benefit from many of these protections.

In order to be meaningful, Congress must enact national patient protections that apply to all Americans with private health insurance. The KMA supports federal legislation that establishes a minimum floor of patient protections that allows stronger state patient protections to remain in place.

REAUTHORIZATION OF AHCPH

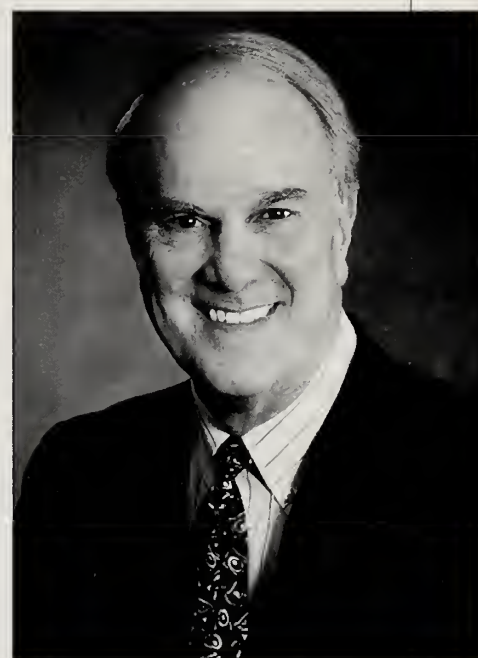
The KMA supports and appreciates Title III of S 326 that reauthorizes the Agency for Health Care Policy and Research and reestablishes it as the Agency for Health Care Research and Quality. The new agency would have appropriate parameters that enhance the quality of health care services through scientific research.

The KMA supports inclusion of Title III in any final patient protection legislation.

In conclusion, the KMA appreciates the Senate's efforts to adopt legislation that would promote fairness in managed care. We urge you to join us in advancing patients' rights by strengthening the "Patients' Bill of Rights Act," S 326, to guarantee all patients these essential protections.

While the debate has ended in the Senate, patient protection legislation is expected to be debated in the House of Representatives. Please contact your Congressman and urge support for Patient Protection. We especially request that you provide personal instances where necessary and urgent patient care has been delayed or denied as a result of managed care decisions. We continue to believe that issues such as who makes decisions relating to determination of medical necessity; the right of every patient to have access to an Independent External Review appeal process; and accountability for all physicians and businesses who make medical decisions relating to patient care, are crucial and non-negotiable to any comprehensive patient protection legislation. We urge every KMA member to continue discussing these issues with your Senators and Representatives.

WILLIAM P. VONDERHAAR, MD NOMINATED FOR KMA PRESIDENT-ELECT



William P. VonderHaar, MD, has been nominated for the office of President-Elect of the Kentucky Medical Association by the Jefferson County Medical Society.

A Louisville family physician, Dr VonderHaar was elected Secretary-Treasurer of KMA in 1990. He served as KEMPAC Chair in 1994 and again in 1996, and has served on numerous committees for several years. Current commitments to KMA include service on the Legislative Quick Action, Continuing Medical Education, Professional Liability Insurance, KMA/KMIC Liaison, and Awards Committees. Dr VonderHaar is a Past President of the Jefferson County Medical Society.

Deeply dedicated to medical education, Dr VonderHaar has held numerous posts at the University of Louisville School of Medicine including Professor and Chair of the Department of Family Practice, Assistant Vice President for Health Affairs, and Clinical Professor in Family Medicine, a position he has maintained since 1981. In 1988, KMA paid tribute to Dr VonderHaar with its Educational Achievement Award. In 1996, the Kentucky Academy of Family Physicians honored him with their Citizen Doctor of the Year Award.

A Charter Fellow of the American College of Family Physicians, Dr VonderHaar has been active in numerous professional societies including both the Kentucky and the American Academy of Family Physicians and the Society of Teachers of Family Medicine.

Born in Davenport, Iowa, Dr VonderHaar received an undergraduate degree in 1952 and a medical degree in 1956 from the University of Louisville. He completed a rotating internship at William Beaumont Army Hospital in El Paso, Texas, in 1957.

Dr VonderHaar and his wife Carolyn Marie reside in Louisville.

KMA News Review

Below are synopses of news items that have appeared recently in various publications regarding issues of interest to Kentucky physicians.

- The Governor of Texas recently signed legislation allowing physicians an antitrust exemption to bargain collectively with health plans. The law will allow independently practicing physicians to negotiate collectively and the state attorney general will supervise the bargaining process. Opponents plan to file suit to overturn the bill. *[Bureau of National Affairs, Health Law Reporter]*
- Some physicians in California are refusing to treat patients in emergency departments because of low fees and late payments. A few emergency departments are paying physicians up to \$1,000 per day for being on call because the problem has become "rampant." *[AMNews]*
- After months of negotiations with federal and state antitrust officials, Aetna has agreed to divest certain HMOs operated by a subsidiary company in Texas so the company may acquire Prudential. The proposed merger would have made Aetna the dominant provider of HMO products in Houston and Dallas, with 63% and 42%, respectively, of enrollees in the area. *[Bureau of National Affairs, Health Law Reporter]*
- Late payments by health plans to hospitals are becoming a major problem nationwide. Many hospital systems claim that health plans intentionally develop "payment ploys" to save money. One hospital administrator said that health plans do not deny procedures, but instead refuse to pay for them after they are delivered, thus shifting the loss to the provider. Some HMOs deny payment after services have been rendered and the patient has either died or been discharged. Many hospitals are just now noticing this trend. The Florida Hospital Association has considered a class action suit to recover some \$75.7 million. *[Modern Healthcare]*
- TennCare, Tennessee's health insurance program for Medicaid recipients, was recently infused with \$190 million by the state legislature. The legislature also passed several bills requiring companies to pay physicians promptly, have adequate networks, and disclose financial information to the state. A recent study of TennCare found that physicians are paid about a third of their normal billable amount. Hospitals report they are getting 50 cents a dollar on their costs on TennCare business, and they now do more charity work than before TennCare was implemented. Six of the nine HMOs that take TennCare patients also lost money in 1998. Another study, however, found that patient satisfaction with the system is high and the number of uninsured in the state has declined. *[Bureau of National Affairs, Health Law Reporter]*
- Many consumer groups are upset that the National Practitioner Data Bank is closed to the general public. The AMA contends that the public may misconstrue such information, but others contend that the information in the Data Bank gives crucial information the public needs in order to choose a physician. Some states have passed laws requiring such information be made available to the public. The first such program was instituted in Massachusetts and the web site containing the information has received over 1.2 million hits. But some, including a malpractice attorney, say the information is "worthless" and only accurate "about 50 percent of the time." *[The Washington Post]*

FAMILY INTERACTIONS AND PSYCHOTIC RELAPSE

John J. Schwab, MD

During this century, the family involvement with and care of mentally ill members has been limited by two factors: 1) the increasing instability of the family itself; and 2) psychiatry's resistance to include family members in patients' treatment programs, usually for fear of loss of confidentiality. Nevertheless, accumulating evidence since the late 1940s shows that deleterious family interactions, especially the level of Expressed Emotion (EE) in the family, is associated with chronically mentally ill patients' relapses. Since the late 1970s, single and multiple family group psychoeducational programs have been developed in the USA and in Great Britain. These programs have been found to reduce the relapse rate of chronic mental illness significantly, especially for high EE families, many of which have members other than the patient with high levels of emotional and physical symptomatology. In view of the high rates of mental illness in the USA, there is a need for family psychoeducational programs and also for family psychiatry.

In this century, two major influences have complicated the role of the family in the course and treatment of mental illness in a family member. One consists of the sociocultural factors related to the pervasive instability of the modern family and to the deterioration of traditional community life. The other is psychiatry's resistance to involving the family in a member's mental illness. My purposes are to look at those two influences, and then discuss the importance of the construct, expressed emotion (EE), in the course (not the cause) and treatment of mental disorder in the family. I conclude with a few remarks about the pressing need for family psychiatry.

The instability, if not breakdown, of the traditional nuclear family is evidenced by statistics on the high divorce rates, large number of single parent families, increasing number of births to unwed mothers (32.6% of all births in 1994), and the shrinking family size.¹ The mod-

ern American family is no longer the yearned for "Haven in a Heartless World" described by Christopher Lasch.²

The instability of the family has been associated with the rapid social change that began in the 1920s and also with the weakening of community life and its accelerated deterioration since the 1960s. What is happening to the family and to the community are circular, reinforcing processes. Family instability devitalizes the community and leads to a loss of the standards, constraints, and social supports that have enriched and protected family life.

These sociocultural developments are intrinsic to our discussion of family influences on psychotic relapse. For example, in their World Health Organization (WHO) research, Cooper and Sartorius raised intriguing questions: inasmuch as schizophrenia is a common psychotic disorder affecting about 1% of the population worldwide, why were there few descriptions of it in the scientific and other literature prior to the mid-19th century?³ Why were early concepts of it not developed until the latter half of the 19th century, between Morel's classic 1852⁴ description of *démence précoce* and Eugen Bleuler's⁵ conceptualization of schizophrenia in 1911?

Cooper and Sartorius argued that the massive industrialization and urbanization in 19th century Europe and America had negative effects on "the size and structure of communities and families." Three concurrent social and medical changes were conducive to the development, not of acute schizophrenia, which, they maintained, has always been present, but to chronic, incapacitating psychotic illness. They were: 1) the increased urbanization that brought schizophrenics together and led to stigmatization; 2) advances in medical technology that lowered mortality among the young and enabled

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more vulnerable persons to survive; and 3) changes in family ties and interpersonal relationships over several generations that affected a schizophrenic person's psychological structures and social interactions adversely and reduced the likelihood of recovery from acute episodes.

In addition, the course of schizophrenia is more benign and relapse is less of a problem in nonindustrialized societies than in the industrialized. In contrast to the industrialized, in nonindustrialized societies, conditions favorable to a relatively benign course include: 1) the large family size and integrated family life that provide stable roles and social supports; 2) the relatively few stressful demands for specialization inasmuch as performance and obligations are based on tradition; 3) concepts of mental illness that acknowledge religion and magic; 4) the small size of towns that allows for tolerance rather than stigma; and 5) the high infant mortality rates that reduce the number of more vulnerable persons.

The second, more direct, negative influence that diminished the role of the family in the course and treatment of a mentally ill member was resistance by the psychiatric profession. Much of it stems from Freud's ambivalence about patients' families, evidenced on one hand by his meetings with families and, on the other, by his fears of family involvement being analogous to relatives "sticking their noses into the field of surgical operations and exclaiming aloud at every incision."⁶ Also, he feared that family involvement would mean losing the patient's confidence and disrupting therapy. The emphasis on strict confidentiality was codified by Freud's followers, and psychoanalysis became devoted to individual therapy. But, by the 1960s, various family therapies were springing up, sometimes wildly. They were based on J.C. Flügel⁷ and Nathan Ackerman's⁸ pioneering efforts and on systems concepts. Those developments, along with advances in genetics and increasing family divorce and distress, contributed to at least partial acceptance of family involvement in mental health care.

THE EXPRESSED EMOTION (EE) CONSTRUCT

In the 1950s, G.W. Brown⁹ saw that relapse was a major problem of schizophrenia in the poorer sections of London, and that, "We knew that something about family life was important to the course of illness, but not what." Research led to identification of the three components of EE associated with relapse—criticism of, hostility toward, and emotional overinvolvement with the patient. Generally, criticism is the most common of the three. Brown and colleagues¹⁰ and others¹¹ acknowledge that EE is not a pure construct, that it is only a model; however, the "black box" called EE reflects family members' attitudes, affects, and behaviors toward their ill relatives.

In 1994, Bebbington and Kuipers¹² analyzed the results of 25 studies of EE in 13 countries. Of the 1346 cases, 52% were living in high EE homes; relapse occurred in 50% of them, but in only 21% of those living with low-EE relatives. The differential between high EE and low EE relapse rates did not vary much in various parts of the world, but relapse was higher in patients not on medications (45%) than in those on medications (32%).

Close contact (35+ hours per week) in high EE families increased the risk of relapse, but was protective for those living with low EE relatives. Positive relationships can exert a salutary influence on chronically ill schizophrenic patients, as evidenced by Ivanovic and colleagues¹³ finding that parental warmth was associated with improved outcomes.

Although repeated studies indicate that EE is a robust construct that has clinical significance, three criticisms of it are:

1. That EE is just a new way of blaming the family for the patient's illness;¹⁴
2. That it was empirically derived and is a "model without a theory";¹⁵ and
3. That the construct is relatively nonspecific and the measurements imprecise.

In response, EE researchers emphasize that it concerns the course of the mental disorder,

the relapse rate, not the cause. Brown's original work on EE did not even look at first admissions but concentrated on EE in relation to relapse.⁹ Also, EE researchers are studying cultural, attributional, and coping theories in an attempt to enlarge its conceptual basis.

Kavanagh's¹⁶ interactive model to explain the link between high EE and relapse postulates that a patient's symptoms produce stress in the home; the relatives' interpersonal behaviors are attempts to cope with the stress. When the coping involves expressions of criticism and emotional overinvolvement, stress is exacerbated and the high EE increases the patient's symptoms. Thus, a vicious circle of negative interactions develops and relapse follows.

Whether EE is related to medication adherence has been questioned. Bebbington and Kuipers¹² found that "The likelihood of consistent medication adherence is no greater in low-EE than in high EE families." They concluded: "At a clinical level, this means that the family atmosphere should not influence the decision to prescribe medication."

NEW DEVELOPMENTS

Bebbington and Kuipers¹² declared that there has been an "explosion of interest" in EE. It includes the following:

1. The development of new assessment instruments. Examples are a short version of the Camberwell Family Interview (CFI), a self-report form, and the Level of Expressed Emotion (LEE) Scale,¹⁷ which addresses the patient's perception of EE, complements relatives' assessments of EE levels, and is useful for studying interpersonal processes.¹⁷
2. Research on high EE and relapse has found that schizophrenic patients express many nonverbal indicators of subclinical psychopathology. Woo and her colleagues¹⁸ videotapes of each of 45 young adult schizophrenic patients and two relatives discussing a family problem revealed patients' nonverbal and paralinguistic expressions of subclinical psychopathology, such as anxious expressions, furrowed brows, trembling,

stuttering, hand-wringing, nervously tapping fingers or feet, etc. Factor analyses identified 3 factors—anxious/agitated behavior, hostile/unusual behavior, and depressed/withdrawn behavior—that accounted for 69% of the variance in the symptom scores. Patients in the 33 (73%) high-EE families manifested significantly more hostile/unusual behavior than those in the 12 (27%) low-EE families who manifested significantly more anxiety and anxious behavior. There were no group differences on the depressed/withdrawn factor. Thus, patients from both high- and low-EE families exhibited subclinical psychopathology that was associated with their families' EE status.

This research has at least two significant clinical implications: 1) It is necessary to consider the patient's contribution to relatives' negative affective attitudes; and 2) family interventions need to address the modification of relatives' subclinical psychopathology as well as their affective attitudes.

3. Barrowclough and Parle's¹⁹ study of the prevalence of emotional distress in a group of schizophrenic patients' relatives and its associations with their appraisals of the patients' behaviors found that 74.6% of patients' relatives were high-EE. At the time of the patient's hospitalization, high-EE relatives had significantly higher General Health Questionnaire (GHQ)²⁰ scores indicative of emotional distress (avg 18.5) than the lower-EE relatives (avg 11.0), and at discharge, the differences were even stronger (avg 12.4 vs avg 2.3).

Using the standard GHQ cut off score of 11, 36 (57%) of the relatives met caseness criteria at the time of the hospitalization, and 19 (30% of the total) remained cases when the patient was discharged. Also, relatives who remained distressed from the time of admission to discharge had higher depression subscale scores than the others. Of those with high depression scores, 90% were high EE, and their ill family members had significantly longer illnesses and more admissions than others. Most low-EE relatives also were

distressed at the time of the patient's hospitalization but made a good adaptation when the patient improved. In contrast, high-EE relatives were likely to continue to be distressed.

Schizophrenic patients' relatives with anxiety and/or depression symptoms tended to overestimate how threatening patients' demands really were (primary appraisal), and to underestimate their own ability to cope (secondary appraisal). Such biased appraisals have detrimental effects inasmuch as relatives' coping will be influenced by their appraisal of the patients' symptoms and by their level of confidence about managing illness situations. Barrowclough and Parle¹⁹ concluded that relatives' appraisals of threat and of efficacy of coping are basic to their reactions to a family member with schizophrenia. They asked: "Can high EE be conceptualized as a form of maladaptive coping?"

The clinical implications of this research are that: 1) the majority of chronically mentally ill patients' relatives, including those rated as low-EE, are experiencing an episode of significant distress at the time of the patient's hospitalization; 2) high-EE relatives of patients with more chronic illnesses are likely to continue to have significant psychological problems when the patient is discharged; and 3) successful interventions need to include helping relatives reduce the threat of the illness experience and to enhance their perceptions of their coping efficacy.

FAMILY PSYCHOEDUCATIONAL INTERVENTIONS

Thus, since Brown⁹ recognized almost 50 years ago that high levels of EE were associated with chronically mentally ill patients' high relapse rates, many studies have found that it is a robust predictor of relapse which has clinical utility. Interest in EE has been accelerating and investigators are now working to refine its conceptual basis and increase its clinical applicability by developing therapeutic interventions, the foremost of which are family psychoeducation programs based on Liberman's²¹ work.

These programs are essential in view of the immense need for treatment of the many chronically mentally ill and the shifting paradigm for health care—the moving of medical and mental patients from hospitals to communities and their families that increases family responsibility and burden. It is critically necessary for families to share and discuss what is known about mental illness and its treatment.

The various family psychoeducational programs have most intervention approaches in common. They engage the family early in a "no-fault" atmosphere; educate about schizophrenia, especially the vulnerability-stress model, theories of etiology, rationale for treatments, and recommendations for coping; provide communication training to improve clarity and problem-solving training to improve management of day-to-day problems and stressful life events; and present crisis intervention techniques for extreme stress and impending relapse. Controlled studies have shown that the programs lower the relapse rate 20% to 40%.²² Also, the programs are associated with improved medication adherence. The three major psychoeducational family interventions are: 1) the individual family with or without the patient; 2) multiple family groups (MFGs) with the patients participating; and 3) relatives only groups. McFarlane²³ reported that MFGs with the patients participating have a lower relapse rate than the more traditional single or other multiple family therapies. His MFGs provide interfamily support, reduce stigma, allow for cross-parenting, and increase family assistance to patients.

McFarlane and colleagues randomly assigned 172 acutely psychotic patients' families to either single family or MFG psychoeducational programs at six public hospitals in New York state. On two-year follow-up, the cumulative MFG relapse rate was only 16%, significantly less than the 27% in the single family treatment groups. MFGs extended severely ill patients' remissions. Also, the mean medication dosage for the MFG group decreased about 20% in contrast to the single family treatment group dosage increase of about 15%. The

MFG groups' symptomatic improvement was clinically significant, evidenced by both lower relapse rates and more employment than other programs.

This study is important because the multi-site collaboration provided for replication of the results. Also, such MFGs may be valuable in managed care settings where hospital stays are brief and patients are symptomatic at time of discharge.

To enhance the therapeutic potential of the short stay in general hospital psychiatric units, Glick and his colleagues²⁴ developed inpatient family intervention (IFI) programs for schizophrenic or affective disorder patients. The programs were designed to reduce high levels of EE and to increase medication compliance. In a randomized clinical trial, the IFI families showed less rejection of the mentally ill family member than the controls and "as a result the medication was taken in a less dissonant family context once the family had been educated about the causes of the illness and its effects." Glick concluded that a key factor was family "empowerment," especially the family's feeling comfortable in ensuring medication compliance.

The following are a few of the new approaches that have proved to be therapeutic, often with high EE families.

1. A 6 week, low cost, MFG psychoeducational program for parents of chronic schizophrenic patients.²⁵ The fathers, compared to the mothers, were more optimistic about the outcome of the illness, more aware of the social and financial impact of the illness on family, and less annoyed by patient behavior. The investigators emphasized that psychoeducational interventions need to consider differences in gender and family roles and to include fathers actively in the intervention programs.
2. The use of psychoeducational programs with bipolar patients and their families. Brennan and colleagues²⁷ reported "overwhelmingly positive" responses to a short term MFG therapy program of weekly 2-hour sessions for 14 weeks. They focused on information about bipolar disorders and on treatment issues, the family as team members, and confidentiality.
3. The timing and sequencing of psychosocial interventions in relation to the various phases of chronic illness. Goldstein and colleagues²⁷ found that psychoeducational programs that focus on the individual family unit were especially effective for first or recent onset of schizophrenia patients, particularly during the stabilization phase of treatment. But, during later phases of treatment and maintenance, relatives only or MFG psychoeducational programs were the most effective.
4. The use of psychoeducational family interventions has spread to many parts of the world. In Norway, Melle and colleagues²⁸ reported that studies of family psychoeducational programs 1982-1991 showed that they decreased the short-term relapse rate in high-EE families. Continuous therapy was of particular benefit; it demonstrated a strong effect after 2 years. Also, additional training in social skills reduced relapse for patients living with *persistently high EE families*.

FAMILY PSYCHIATRY

I close with a plea for us to promote the development of family psychiatry. The family has been celebrated as the oldest human institution, known through the ages, in Aristotle's terms, as the basic social unit.

There are three compelling reasons for more family psychiatry in the USA. The first is the extensive, apparently increasing, prevalence of mental disorder. In the early 1980s, the Epidemiologic Catchment Area study (ECA)²⁹ reported that the 12-month prevalence rate of mental disorders in the USA was 20.0%. In 1994, just 10 years later, the National Comorbidity Study (NCS)³⁰ reported that the 12-month prevalence rate was 29.5%, an increase of about 50%. Inasmuch as these are reports of DSM-III diagnosed disorders, we can see that the prevalence of mental illness is awesome, outstripping treatment facilities and services. Almost every family now contains a member or a near relative who has a mental disorder. Moreover, the

three major causes, often in combination, are genetic factors, social stress, and family problems/dysfunctions.

The second reason is that mental health care, in accord with the shifting paradigm in health care, is placing families in the position in which they are forced either to provide care or to abandon their mentally ill members. This "either—or" choice involves family burden on one hand or guilt and distress on the other.

The third is based on the massive family instability and indicators of increased rates of mental disorder, especially depression, in such groups as the divorced and the separated.³⁰ As early as 1958, Galdston³¹ stated flatly that the American family was in crisis and that concerns about mental health and illness should include questions about the family, the health of the community, and how the community contributes to the health and illness of its families.

Grunebaum³² has offered a meaningful definition of family psychiatry as: "That body of knowledge that psychiatrists, family physicians and mental health workers should have to understand best the origins of psychopathology and to work therapeutically with individuals, couples, or families." Family psychiatry is intrinsically interesting. Evaluations of families are from three perspectives: 1) the historical—how the problem arose and from what roots; 2) the interactional—which assesses the roles and behaviors of family members; and 3) the existential—which focuses on what it means to be a member of a particular family living in a certain community. Thus, the scope of family psychiatry extends from special concerns about children at risk, especially those whose parents have mental disorders, those who are victims of family violence, and those growing up in fatherless families, to various, often innovative family treatments, and how cultural and community processes influence family life.

One of my concerns during the past 10 years has been that we, in Kentucky, have few psychoeducational family programs for families and their chronically mentally ill members. Although patients and family members ask about the availability of multiple family and

other family group interventions, we have little to offer them.

In view of the need for, but glaring lack of family interventions for the care of the chronically mentally ill, I have been using individual family psychoeducational approaches. I see patients, spouses, and other family members for single family treatment modeled on such basic psychoeducational principles as the no-fault atmosphere and a stress-vulnerability model for mental illness and relapse and on the concepts and practices of pragmatic family intervention.³³ They include discussions of current information about the etiology, course, and treatment of mental disorder and its effects on the children, the prevention of recurrences, and techniques for coping. In light of the increasing acceptance and successes of psychoeducational programs in such nations as Egypt³⁴ and China,³⁵ as well as in the western world, it behooves us to mount those needed programs in Kentucky.

ACKNOWLEDGEMENT: The author thanks Ms Anne Bickel for her superb assistance in the preparation of this manuscript.

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Daniel P. Garcia, MD

ENVIRONMENTAL ECOLOGY: UNPROVEN AND EXPERIMENTAL METHODOLOGY DOES IT EXIST?

A recent paper published by the Board of Directors of the American Academy of Allergy Asthma and Clinical Immunology (*J Allergy Clin Immunol* 103:36-40, 1999) gives a position on one of the hottest topics in primary care and allergy today: multiple chemical sensitivity, or what has been more recently termed idiopathic environmental intolerances (IEI) by the World Health Organization.

In short, advocates of this approach to medicine attribute a wide range of "clinical symptoms" to numerous environmental substances such as food, water, chemicals, and pollutants. Practitioners of such medicine label themselves as "ecologically oriented" and to date have no precise definition or diagnostic criteria on which to base their practice of such medicine. Characteristically, patients are female with multiple organ system complaints. Symptoms often demonstrated have included hypertension, learning disabilities, headaches, arthritis, depression, chronic fatigue, respiratory problems, urinary complaints, and a myriad of psychiatric complaints. In actuality, there are few symptoms that haven't been related IEI. Physical examination and laboratory findings are inconclusive. The patients are often convinced

that exposure to solvents, pesticides, perfumes, food additives, drugs, electromagnetic fields, and dental mercury are precipitins of IEI. On the other hand, some patients are unable to pinpoint any triggers associated with the onset of symptoms; however, a specific initiating event may be more likely incriminated when contemplating personal injury litigation or in the event of workers compensation.

The diagnosis of IEI is based solely on the patient history since validated laboratory testing is usually lacking. Clinical ecologists have proposed a variety of immunologic and toxicologic theories, while others suggest a psychologic origin. The former respond by saying that psychopathology is the ultimate result and not the primary cause of the illness.

Treatment may include IVIG, vitamins, minerals, homeopathic remedies, and various supplemental therapies, all of which lack research data to support their use. Psychotherapy is sometimes recommended as well as "environmentally safe" homes, communities, or living complexes sympathetic to this cause. Diets can be very restricted with foods often introduced in a rotational or cyclic manner. Foods with any dyes, colorings, or additives are

Practitioners of such medicine label themselves as "ecologically oriented" and to date have no precise definition or diagnostic criteria on which to base their practice of such medicine.

eliminated, and at times, a total elimination diet may be instituted with the exception of spring water followed by oral challenges with less "contaminated foods." Patients can be admitted into environmental units that are presumably chemically free environments. Socially, the lives of these people can be very restrictive and almost reclusive. Not infrequently they can be alienated from friends and family, not to mention their physicians. Patients are often treated with solutions of "allergens" given by injection or in a sublingual manner. These antigens are initially given in very low dosages and often preceded by provocation and neutralization techniques. Other forms of treatment may include mold allergens, pollen therapy, and other forms of immunotherapy to include phenol, formaldehyde, histamine, and serotonin. Psy-

chiatrists have noted similarities to somatoform/conversion reactions and have recognized that IEI may be a part of a spectrum of non-physical illnesses since many of these patients exhibit numerous physical complaints. For certain, IEI are to be differentiated from those disorders that are well characterized as diagnosable and environmentally caused diseases such as carbon monoxide poisoning, hypersensitivity pneumonitis, antigen/chemical induced bronchial hyper-reactivity, etc . . .

In short, IEI, in its present context, lacks any established factual data to support its existence as a dysregulation of the immune system. Controlled studies to define solid objective and plausible parameters for this illness are clearly lacking. To date there has been an obvious lack of patient assessment data and properly controlled studies to evaluate the numerous methods of treatment. Anecdotal publications without controlled studies fail to substantiate a causal relationship between this

"illness" and "environmental toxins." The American Academy of Allergy and Immunology has stated in previous Position Statements that the use of subcutaneous and sublingual provocation neutralization procedures are unproven. The Practice Standards Committee of the Academy has recently carefully reviewed data presented by a number of medical ecologists and has not rescinded their decision nor their recommendations concerning these controversial techniques.

On the other hand, one cannot deny the fact that we can often be faced with the patient with multiple system complaints for which we are unable to properly diagnose or treat, and we have to be very cautious in labeling these patients as psychosomatic or supratentorially oriented. After all, these are the people who often doctor shop and end up at the mercy of the ecology doctor. We should not forget that when faced with such a patient one of our roles as a healing physician is to offer a

... a specific initiating event may be more likely incriminated when contemplating personal injury litigation or in the event of workers compensation.

lending ear, have a non-judgemental attitude, give a gentle touch on occasion, and to have the wisdom and discernment to order appropriate lab data base to enable us **to tell the patient with reasonable certainty what he or she may not have.**

Any physician who advises patients, insurance carriers, or attorneys at law on this hot topic will find reading this article invaluable and should retain it for reference purposes.

Daniel P. Garcia, MD



Carolyn Daley

KENTUCKY MEDICAL ASSOCIATION ALLIANCE 1999 FALL BOARD MEETING

The Kentucky Medical Association Alliance Fall Board meeting will be held on Tuesday, September 28 at the Hyatt Regency Hotel in Lexington, Kentucky. All KMAA, KMA members and guests are welcome to attend the meeting. An Idea Fair will be held at 9 am where a physician will educate the Alliance about osteoporosis, breast cancer awareness, and organ donation. The KMAA has joined with the National Osteoporosis Foundation (NOP) and hundreds of health providers across America as a Partner in Prevention. As a partner, the KMAA is participating in the National Osteoporosis campaign to educate the public about the prevention of osteoporosis. The Partners in Prevention 30-minute slide presentation and script, "Osteoporosis; The Silent Disease," will be available for review. The presentation was designed for the education of the general public at lectures or seminars. One in two women and one in eight men are at risk for a fracture as a result of osteoporosis. According to the National Osteoporosis Foundation, our nation spends approximately \$13.8 billion a year on osteoporosis. The KMAA encourages physicians to educate their patients about osteoporosis and to recommend a bone density test

when indicated. Please contact the KMA Alliance office if you would like to use the osteoporosis slide presentation.

The Live and Then Give video will be available for your review at the Idea Fair. The video about organ donation was a joint project of the Texas Medical Association, TMA Alliance, Texas Transplantation Society, and the TMA Foundation. The KMA Alliance promotes education about organ donation. The video is also available from the KMA Alliance office.

Many hospitals offer a special rate for mammograms during October, breast cancer awareness month. In order to take advantage of the special rate, the October appointment may need to be scheduled in August. The KMAA encourages all women over 40 to speak to their physician about mammography. All KMAA members and physician spouses should check with their physician to determine whether a mammogram is indicated. Prevention is the best cure. Early detection saves lives. A silent auction of two *Horizon of Hope* Longaberger baskets will be held at the Idea Fair. The *Horizon of Hope* baskets were created by the Longaberger company to spread awareness about breast cancer. The proceeds of the basket auction will benefit cancer research at the University

of Kentucky and the University of Louisville medical schools.

The Idea Fair will also include membership, legislative, other health education materials, "Reach Out and Read," literacy, and AMA Foundation information.

SuEllen Fried, coauthor of the book *Bullies and Victims, Helping Your Child Through the Schoolyard Battlefield*, will present information contained in her book to the KMA Alliance. According to the National Education Association, 160,000 students miss school every day because of fear about bullying. Elementary school bullies have a one-in-four chance of becoming a criminal, according to Mrs Fried. She states that children need certain skills in order to be prepared to deal with peer conflicts: social skills and self-esteem, conflict and mediation skills, respect for differences and diversity, assertiveness and anger management skills, problem solving skills, empathy, and sexuality awareness. Bullying may take the form of physical, verbal, emotional, or sexual abuse. Mrs Fried has been president of the Kansas Mental Health Association and was named as former President Bush's 900th Point of Light. She has presented papers at the International Conferences on Child Abuse which were held in Amsterdam, Paris, Montreal, and

Chicago. The KMA Alliance has made arrangements with the Fayette County Public Schools for SuEllen Fried to work with 4th and 5th graders in two elementary schools, and 6th graders in a middle school. She will also conduct a training session for teachers and school counselors. She will conduct a workshop for the Kentucky Association of School Social Work at their Annual Conference. Alliance members are welcome to attend these additional presentations on Wednesday and Thursday morning.

A representative from the AMA Alliance will speak at our Fall Board meeting about the leadership role of the medical family in today's society. She will also discuss how the Alliance can help to Stop America's Violence Everywhere (the AMAA SAVE program).

The KMA Alliance welcomes KMAA, KMA members, spouses, and guests to attend our meeting and to visit our Hospitality Suite for refreshments and information about our projects for the year.

SCHEDULE		
Tuesday	September 28, 1999	Patterson A—Lower Level B
8-10 AM	Registration	
7	Hospitality Suite Opens	
7:30	Executive Committee meeting	
8-8:55	Planning Committee	
9-9:50	Idea Fair: A Physician will educate the Alliance about Osteoporosis, Breast Cancer, and Organ Donation	
	KMAA Vice-Presidents will present materials for Membership, Legislation, Health Promotion, and AMA Foundation	
10-11:30	Board meeting	
12-1:30 PM	Lunch with guest speaker and entertainment	
1:30-3	Educational seminar, SuEllen Fried	
3:15	Finance and Bylaws Committee meeting	

The KMAA Board Meeting will be held in room Patterson A on lower level B. Registration is adjacent to Patterson A.

Please make plans to join us for a fun and informative KMAA

Fall Board meeting. We look forward to seeing you.

Carolyn B. Daley
KMAA President



MAKE PLANS NOW TO ATTEND THE
37TH ANNUAL
KEMPAC POLITICAL SEMINAR-DINNER

DATE:	Monday, September 27, 1999
TIME:	6:00 PM EDT Reception 7:00 PM EDT Dinner & Program
LOCATION:	Hyatt Regency Hotel Lexington, KY

Tickets may be purchased from the KEMPAC Office for \$30 each. Make checks payable to KEMPAC and mail with the form below to:

KEMPAC
4965 US Highway 42, Suite 2000
Louisville, KY 40222

----- ✂ ----- ✂ ----- ✂ ----- ✂ -----
Name _____

Address _____

Amount Enclosed _____

No. of Tickets _____

1999
PRELIMINARY PROGRAM



HEALTHCARE
ALTERNATIVES



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**For your convenience these pages are in a special pull-out section.*

OFFICIAL CALL KMA ANNUAL MEETING

To the officers and members of the component and county medical societies of the KMA.

Meeting Place

The Annual Meeting of KMA will convene on Monday, Tuesday, Wednesday, and Thursday, September 27, 28, 29, and 30, at the Hyatt Regency Hotel and Lexington Center, Lexington. The first General Session will be called to order at 8:30 AM, Tuesday.

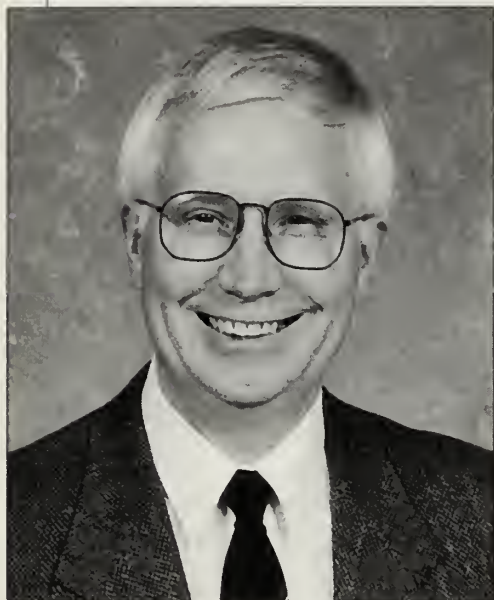
The House of Delegates

The first regular meeting of the House of Delegates will convene at 10:00 AM, Monday, September 27, in the Regency Ballroom, located in the Hyatt Hotel. The second regular business meeting will begin at 7:00 PM, Wednesday, September 29, in the Patterson Ballroom.

Registration

The Registration Desk, located outside the Regency Ballroom, Lobby Level of the Hyatt Hotel, will be open for Delegates at 8:30 AM, Monday, September 27, and at 6:00 PM, Wednesday, September 29. General registration will be held from 7:30 AM until 5:00 PM on Tuesday and 7:30 AM to 4:00 PM on Wednesday, at the General Registration Desk located in the lobby of the Lexington Center.

KMA OFFICERS 1998-99



DONALD R. STEPHENS, MD
KMA President

On Wednesday, September 29, Donald R. Stephens, MD, Cynthiana, will pass the mantle of leadership of the Kentucky Medical Association to Harry W. Carloss, MD, Paducah.

Dr Stephens has been diligent in his many years of dedicated service to organized medicine, which includes 23 years as 9th District KMA Delegate, several years as an Alternate Trustee, three terms as Trustee, Chair of the KMA Board of Trustees for two terms, Vice President, President-Elect, and President. His commitment continues with current service on the following committees: Professional Liability Insurance (PLI), Public Education, Scientific Program, Legislative Quick Action, Managed Care, and KMA/KMIC Liaison.

Dr Stephens has provided effective leadership during a very challenging year for physicians. He exemplifies the best qualities of a physician, and KMA recognizes and appreciates the many contributions of this self-proclaimed "country doc."



HARRY W. CARLOSS, MD
President-Elect

Harry W. Carloss, MD, will be installed as President of the Kentucky Medical Association at the President's Luncheon on Wednesday, September 29.

An internist practicing in Paducah, Dr Carloss served as 1st District KMA Delegate for 13 years; 5 years as a Trustee; one term as Vice Chair and two terms as Chair of the Board of Trustees; and as Vice President prior to his election as President-Elect. He has served since 1992 on the KEMPAC Board. Current commitments include service on the following committees: Cancer, Physician Advisory to Health Kentucky, PLI, Public Education, Scientific Program, and Legislative Quick Action.

Dr Carloss is an Associate Clinical Professor of Medicine at the University of Louisville and an Assistant Professor of Internal Medicine at the University of Kentucky. He is deeply committed and devotes many hours to cancer research, cancer treatment, and Hospice endeavors.

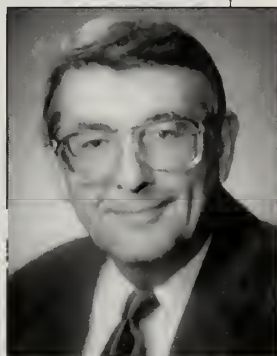
A native Kentuckian, Dr Carloss is a 1971 graduate of the University of Kentucky and a 1975 graduate of the University of Louisville School of Medicine. Following an internship and residency at the University of Louisville, he completed a 2-year fellowship at Scripps Clinic and Research Foundation, Division of Hematology/Oncology, one year of which he served as Chief Hematology Fellow and Chief Fellow.

DONALD R. NEEL, MD
Vice-President



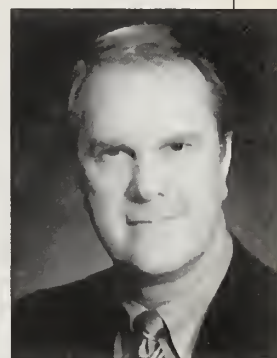
Dr Neel, a pediatrician practicing in Owensboro, served as a 2nd District KMA Delegate for 3 years and as a Trustee for 4 years prior to his 1998 election as Vice President. He currently chairs the Medicaid Managed Care and Medical Insurance & Prepayment Plans Committees, and also serves on the Child & School Health, PLI, Managed Care, and Maternal & Neonatal Health Committees. A 1964 graduate of the University of Kentucky College of Medicine, Dr Neel is a Past President of the Daviess County Medical Society and is a member of the Kentucky Pediatric Society and the Flying Physicians Association.

JOHN W. MCCLELLAN, JR, MD
Speaker of the House



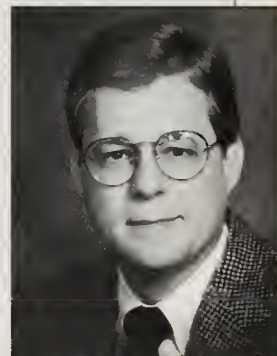
Dr McClellan, a family physician, served KMA for several years in the House of Delegates and as 2nd District Alternate Trustee from 1982 until 1988 when he was elected Trustee. In 1994, he was elected Vice Speaker, a position he held until 1996 when he was elevated to Speaker. A 1960 graduate of the University of Louisville School of Medicine, Dr McClellan is a past President of the Henderson County Medical Society.

WILLIAM P. VONDERHAAR, MD
Secretary-Treasurer



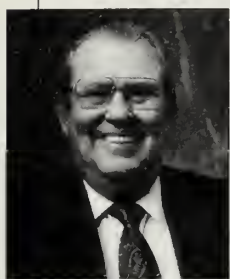
A Louisville family physician, Dr Vonderhaar was elected Secretary-Treasurer in 1990, served as KEM-PAC Chair in 1994 and again in 1996, and currently serves on the Legislative Quick Action, Continuing Medical Education, Professional Liability Insurance, KMA/KMIC Liaison, and Awards Committees. Dr Vonderhaar was recipient of KMA's Educational Achievement Award in 1988 and is a past honoree of the Citizen Doctor of the Year Award presented by the Kentucky Academy of Family Physicians.

THOMAS K. SLABAUGH, MD
Vice Speaker of the House



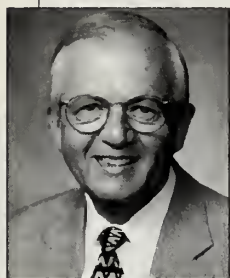
In 1996, Dr Slabaugh, a Lexington urologist, was elected to complete a term as Vice Speaker. In 1998, he was reelected to serve a 3 year term as Vice Speaker. He has served as a KMA Delegate for Fayette County for several years and is a Past President of the Fayette County Medical Society. He currently serves as Chair of KMA's CME Committee. Dr Slabaugh earned his medical degree from the University of Virginia in 1973.

KMA DELEGATES TO THE AMA



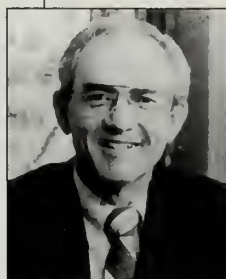
DONALD C. BARTON, MD
Corbin

Dr Barton, a family physician, was elected AMA Delegate in 1984. A past Chair of the KMA Board of Trustees and past KMA President, his extensive service includes KMA Delegate; AMA Alternate Delegate; Vice Chair, Southeastern Delegation, AMA; past Chair of KEMPAC Board; and 15th District KMA Trustee for several years. Dr Barton chairs the Committee on National Legislative Activities and the Physician Advisory Committee to Health Kentucky. He also serves on the Awards and State Legislative Activities Committees. In 1993, Dr Barton received KMA's Distinguished Service Award.



WALLY O. MONTGOMERY, MD
Paducah

Dr Montgomery, a general surgeon, was elected AMA Delegate in 1988. He served KMA as Trustee for several years, as Vice-President, President-Elect, President, Alternate AMA Delegate, KEMPAC Chair, and on numerous committees. He chairs the State Legislative, Legislative Quick Action, and PLI Committees and is a member of the Awards Committee. Dr Montgomery is a past KY Governor and past President of the KY Chapter of the American College of Surgeons and a diplomate of the American Board of Surgery. In 1990, he was recipient of KMA's Distinguished Service Award.



ROBERT R. GOODIN, MD
Louisville

Dr Goodin, a cardiologist, was elected AMA Alternate Delegate in 1986 and Delegate in 1990. In 1996, he became a member of the AMA Council on Medical Education. He has served KMA as President-Elect and President, and currently chairs the Physician Workforce Committee and the Ad Hoc Committee on Cardiovascular Services. Dr Goodin also serves on the CME and Managed Care Committees and is Vice Chair of the National Legislative Activities Committee.



ARDIS D. HOVEN, MD
Lexington

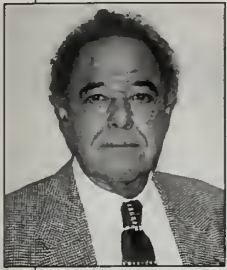
Dr Hoven, an infectious disease specialist, was elected AMA Delegate in 1993, following service as an AMA Alternate Delegate from 1989-93. She serves on the AMA Council on Medical Service. Past service to KMA includes President-Elect and President. She currently chairs the KMA Membership Task Force and is a member of the Community and Rural Health Committee and Subcommittee on Domestic Violence.



DONALD J. SWIKERT, MD
Florence

Dr Swikert, a family physician, was elected AMA Delegate in 1994. He served as AMA Alternate Delegate from 1989-94. Dr Swikert was the founding Chair of the Young Physicians Steering Committee, a KMA Alternate Trustee in 1985-88, and currently serves on the Awards, Medicaid Managed Care, Community and Rural Health and Complementary and Alternative Therapies Committees. Dr Swikert is a Past President of the Northern Kentucky Medical Society and the Kentucky Academy of Family Physicians.

JOURNAL EDITORS



A. EVAN OVERSTREET, MD
EDITOR
Louisville

Dr Overstreet served on the Editorial Board for more than 6 years before becoming Editor of *The Journal* in September 1977. An internist, Dr Overstreet is a 1955 graduate of the University of Louisville School of Medicine. He is a member of the American Society of Internal Medicine, the American College of Physicians, the Transylvania Medical Society, and former President of the Louisville Society of Internists.



KIMBERLY A. ALUMBAUGH, MD
Louisville

Dr Alumbaugh, an obstetrician-gynecologist, joined *The Journal* in 1996 as an Assistant Editor. A 1986 graduate of the University of Missouri at Columbia, Dr Alumbaugh is active in several professional organizations, including the American College of Obstetrics and Gynecology.



CAROLYN D. BURNS, MD
Louisville

Dr Burns, a pathologist, joined *The Journal* in 1995 as an Assistant Editor. A 1986 graduate of the University of Missouri School of Medicine, Dr Burns is an Associate Clinical Professor in the University of Louisville Department of Pathology and a member of several professional organizations including the American Society of Clinical Pathologists, College of American Pathologists, and the International Academy of Pathology.



DANIEL P. GARCIA, MD
Louisville

Dr Garcia joined *The Journal* in early 1998 as an Assistant Editor. An allergist, he is a 1973 graduate of the University of Louisville School of Medicine. Dr Garcia is a diplomate of the American Board of Allergy, Asthma and Clinical Immunology, a member of several professional organizations, and extensively involved in community and philanthropic endeavors.



STEPHEN Z. SMITH, MD
Louisville

Dr Smith has served as Assistant Scientific Editor for *The Journal* since 1977. He also serves as book review author. A dermatologist, Dr Smith is a 1971 graduate of Johns Hopkins University School of Medicine. He is a member of several professional organizations including the American Academy of Dermatology and serves on the KMA Committee on Complementary and Alternative Therapies.



JAROSLAV P. STULC, MD
Madisonville

Dr Stulc, a surgeon, joined *The Journal* in 1994 as an Assistant Editor. A 1973 graduate of the University of Iowa College of Medicine, Dr Stulc is affiliated with the Trover Clinic in Madisonville. He is a diplomate of the American Board of Surgery, a fellow of the American College of Surgeons, and an instructor for Advanced Trauma Life Support (ATLS). In addition to his duties at Trover Clinic, Dr Stulc serves as Commander, United States Naval Reserve Medical Corp-Active Duty.



DANIEL W. VARGA, MD
Louisville

Dr Varga joined *The Journal* in 1990 as Scientific Editor. An internist, he is a 1984 graduate of the University of Louisville School of Medicine. He serves as KMA's 5th District Trustee, has served as Alternate Delegate and Delegate to the KMA House of Delegates, and is a Past President of the Jefferson County Medical Society. Dr Varga chairs the Committee on Complementary and Alternative Therapies and is a member of the KMA Medicaid Managed Care Committee and the Committee on Child and School Health.

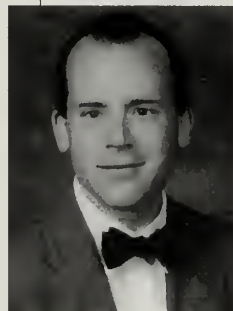
KMA DISTRICT TRUSTEES



Robert C. Hughes, MD
Murray



First District



Daniel W. Varga, MD
Louisville



Fifth District



David A. Watkins, MD
Henderson



Second District



John T. Burch, MD
Bowling Green



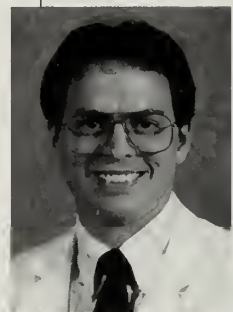
Sixth District



Uday V. Dave, MD
Madisonville



Third District



John M. Patterson, MD
Frankfort



Seventh District



Eugene H. Shively, MD
Campbellsville



Fourth District



Thomas E. Bunnell, MD
Crestview Hills



Eighth District



J. Gregory Cooper, MD
Cynthiana



Ninth District



Andrew R. Pulito, MD
Lexington



Tenth District



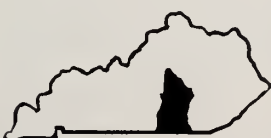
Richard A. Stone, MD
Richmond



Eleventh District



Donald E. Brown, MD
Somerset



Twelfth District



Kenneth R. Hauswald, MD
Ashland



Thirteenth District



Baretta R. Casey, MD
Pikeville



Fourteenth District



Meredith J. Evans, MD
Middlesboro



Fifteenth District



ELECTIONS

NOMINATING COMMITTEE TO MEET MONDAY, SEPTEMBER 27

The KMA Nominating Committee will hold an open meeting at the close of the first meeting of the House of Delegates on Monday, September 27, 1999, in the Regency Ballroom of the Hyatt Regency Hotel, Lexington. Any KMA member may confer with the committee during this meeting.

The report of the Nominating Committee will be posted in the general sessions hall in Lexington Center at the conclusion of the first general session, Tuesday morning, September 28.

Nominations may be made from the floor during the second meeting of the House of Delegates on Wednesday evening, September 29. The House will vote on the nominees at this meeting.

Members of the Nominating Committee are: Barbara A. Phillips, MD, Lexington, Chair; David E. Bybee, MD, Louisville; J. Roger Potter, MD, Ashland; and Scott A. Watkins, MD, Henderson.

Nominations should be sent before the Annual Meeting to the KMA Headquarters Office to the attention of the Nominating Committee.

HOUSE TO ELECT NEW OFFICERS DURING ANNUAL MEETING

KMA officers for the 1999-2000 Association year will be elected by the House of Delegates at the close of its final meeting, Wednesday evening, September 29. Officers to be elected from the state-at-large are:

Office	Term
President-Elect	1 Year
Vice President	1 Year
Secretary-Treasurer	3 Years
Delegates to AMA	2 Years
* Donald C. Barton, MD, Corbin	
** Ardis D. Hoven, MD, Lexington	
Alternate Delegates to the AMA	2 Years
** J. Gregory Cooper, MD, Cynthiana	
** Baretta R. Casey, MD, Pikeville	
* Not seeking reelection	
** Incumbent	

ELECTION OF TRUSTEES AND ALTERNATE TRUSTEES

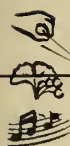
The House of Delegates will elect five District Trustees and six Alternate Trustees at its second regular meeting, Wednesday, September 29, 1999. Nominations will be made by the Delegates from the electing Districts at a meeting following the first meeting of the House, on Monday, September 27.

The Nominating Committee will report at the close of the first scientific session on Tuesday, September 28. Further nominations may be made from the floor at the final meeting of the House on Wednesday evening, September 29. All nominations are considered and acted upon by the Delegates at this final meeting.

Districts electing Trustees for 3-year terms are: 5th District (incumbent Daniel W. Varga, MD, Louisville); 6th District (incumbent, John T. Burch, II, MD, Bowling Green); 8th District (incumbent, Thomas E. Bunnell, MD, Crestview Hills); 11th District (incumbent, Richard A. Stone, MD, Richmond); and 15th District (incumbent, Meredith J. Evans, MD, Middlesboro). All are eligible for reelection.

Districts electing Alternate Trustees are the same as those electing Trustees. Incumbents are: 5th District, Susan M. Berberich, MD, Louisville; 6th District, J. Michael Pulliam, MD, Franklin; 8th District, James P. Farrell, MD, Crestview Hills; 11th District, Suvas G. Desai, MD, Richmond; and 15th District, David W. Douglas, MD, London. All are eligible for reelection.

In addition, there is a vacancy in the 2nd District, and an Alternate Trustee needs to be elected to complete the final year of a three-year term left vacant when David Watkins, MD, assumed the Trustee position in 1998.



ABRIDGED SCHEDULE OF ANNUAL MEETING EVENTS

LC = Lexington Center
HH = Hyatt Regency Hotel

Sunday, September 26

9:00 AM KMA Executive Committee Meeting
12:30 PM KMA Board of Trustees Meeting & Lunch
6:00 PM KMA Board of Trustees Dinner

Regency Ballroom East - HH
Regency Ballroom West - HH
Kentucky Room - HH

Monday, September 27

8:30 AM Registration for House of Delegates
8:30 AM Continental Breakfast for House of Delegates
10:00 AM First Meeting, KMA House of Delegates
11:45 AM Trustee Districts Nominating Committees/
KMA Nominating Committee
11:45 AM Rural Caucus/Luncheon
12:00 PM Reference Committee Chair Luncheon
1:00 PM Reference Committee Meetings
3:00 PM Collective Bargaining for Physicians Seminar
6:00 PM KEMPAC Reception & Dinner

Regency Ballroom Foyer - HH
Regency Ballroom East - HH
Regency Ballroom - HH

Regency Ballroom - HH
Chicago/Atlanta Room - HH
San Francisco Room - HH
Patterson Meeting Rooms - HH
Chicago/Atlanta Room - HH
Regency Ballroom - HH

Tuesday, September 28

7:00 AM KEMPAC Board Breakfast Meeting
7:00-9:00 AM Reference Committee Report Signing
7:30 AM Registration
7:30 AM KMAA Registration
7:30 AM KMAA Various Meetings/Fall Board Meeting
8:15-9:00 AM Free Coffee and Danish
8:30 AM Opening Ceremonies, First Scientific Session
12:00 PM Young Physicians Luncheon
12:00 PM KMAA Luncheon
12:00 PM Executive Committee & Reference Committee
Chair Luncheon Meeting
1:00 PM MSS/RPS Annual Meeting
1:30 PM Specialty Group Sessions...11 Specialty Groups
will meet simultaneously at this time.

Regency Ballroom Center - HH
Mary Todd Lincoln Room - HH
Registration Area - LC
Outside Patterson A - HH
Patterson A - HH
Exhibit Hall - LC
General Sessions Area - LC
Kentucky Room - HH
Regency Center - HH

Atlanta Room - HH
Patterson B - HH
Various Meeting Rooms - LC/HH

Wednesday, September 29

7:30 AM Registration
8:15-9:00 AM Free Coffee and Danish
8:30 AM Second Scientific Session
11:50 AM President's Installation/Awards Luncheon
2:15 PM Specialty Group Sessions...10 Specialty Groups
will meet simultaneously at this time.
3:00 PM KMA Board of Trustees Meeting
5:00 PM Rural Caucus Meeting/Dinner
6:00 PM Registration for House of Delegates
7:00 PM Second Meeting, KMA House of Delegates

Registration Area - LC
Exhibit Hall - LC
General Sessions Area - LC
Patterson Ballroom - HH
Various Meeting Rooms - LC

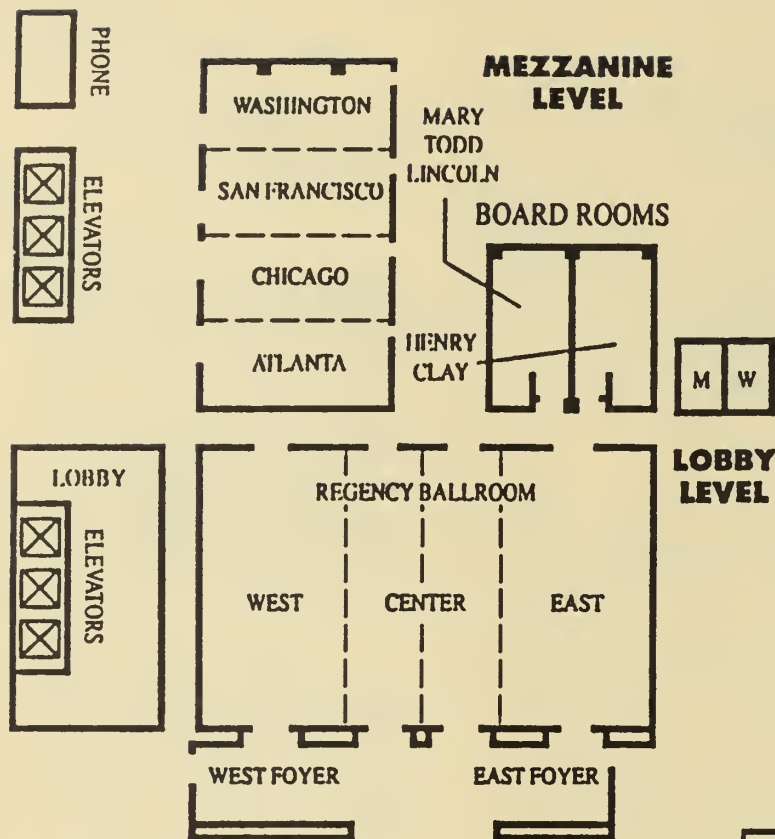
Atlanta-Washington Rooms - HH
Regency West - HH
Outside Patterson Ballroom - HH
Patterson Ballroom - HH

Thursday, September 30

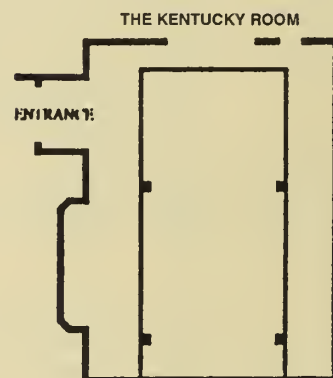
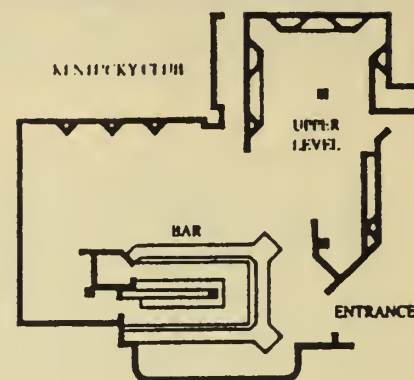
7:30 AM KMA Board of Trustees Breakfast Meeting

Regency Ballroom West - HH

*A 30-minute intermission has been scheduled during each Scientific Session
And Specialty Group Session for visiting Exhibits.*

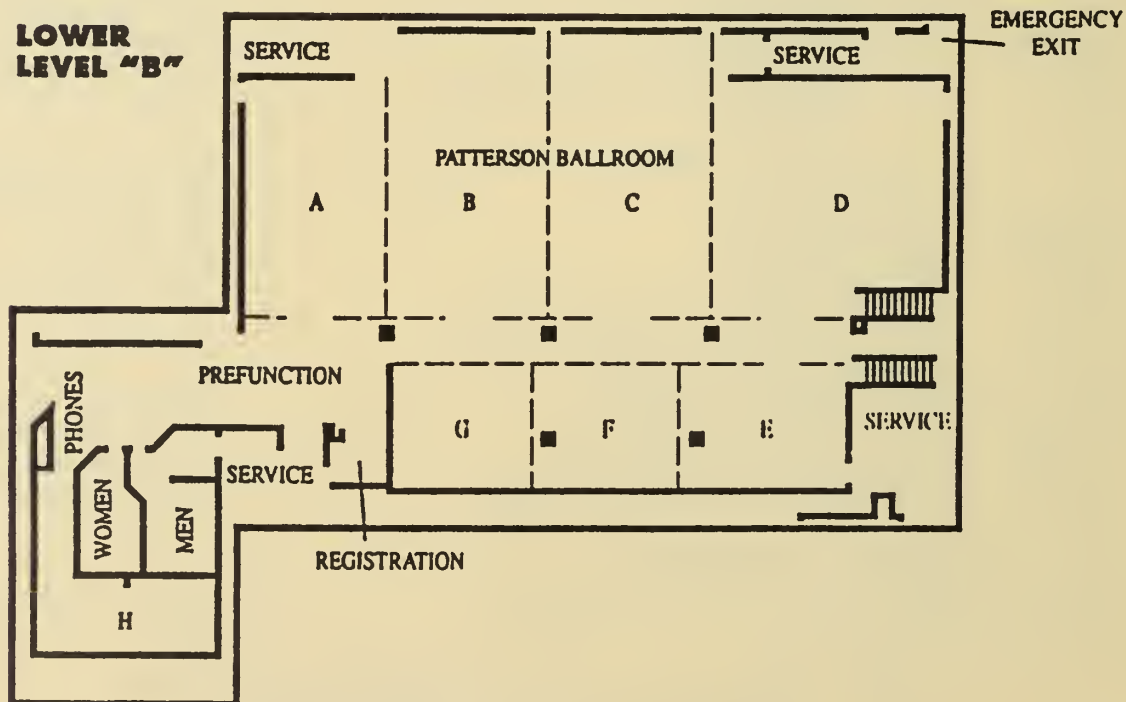


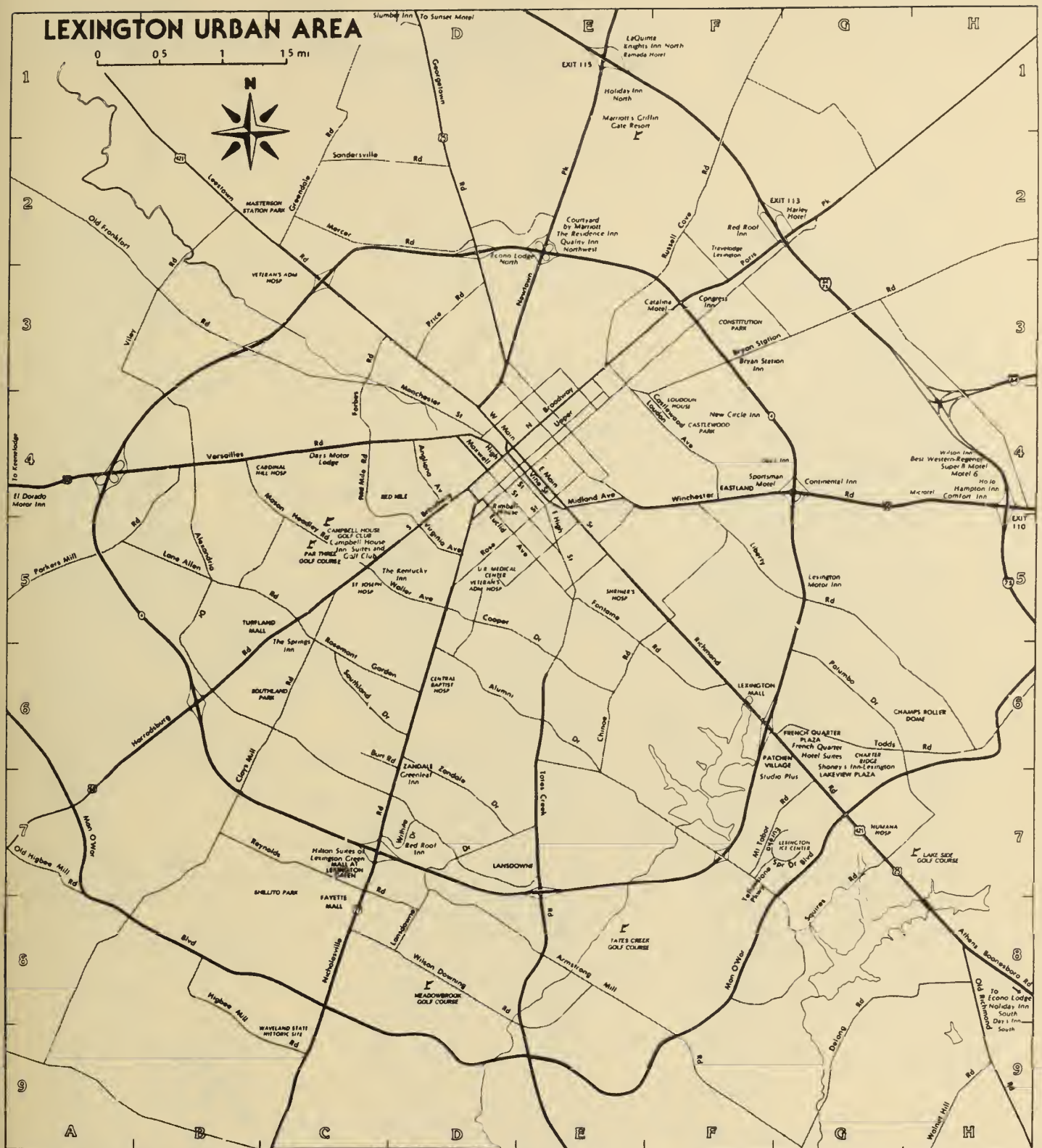
LOWER LEVEL "A"



Hyatt Regency Lexington

LOWER LEVEL "B"





The Greater Lexington Convention and Visitors Bureau welcomes you to the heart of the Bluegrass.

KMA DELEGATES

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CALLOWAY

Robert C. Hughes, MD, Murray

Robert Williams, MD, Murray

CARLISLE

FULTON

GRAVES

Charles Bea, MD, Mayfield

Gerald Russell, MD, Mayfield

HICKMAN

Bruce Smith, MD, Clinton

LIVINGSTON

MARSHALL

MCCRACKEN

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David Jones, MD, Owensboro

Wathen Medley, MD, Owensboro

William Milnor, MD, Owensboro

Linda Mumford, MD, Owensboro

Terry Tyler, MD, Owensboro

William Tyler, MD, Owensboro

HANCOCK

HENDERSON

John Cave, MD, Henderson

Marshall Howell II, MD, Henderson

Scott Watkins, MD, Henderson

McLEAN

OHIO

UNION

WEBSTER

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HOPKINS

Wallace Alexander, MD, Madisonville

James Bowles, MD, Madisonville

Uday Dave, MD, Madisonville

Mohan Rao, MD, Madisonville

MADISONVILLE

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Robert Bressler, MD, Hopkinsville

Guinn Cost, MD, Hopkinsville

John E. Cotthoff, MD, Hopkinsville

Peter R. Isele, MD, Hopkinsville

Daniel A. Lopez, MD, Hopkinsville

J. Nicholas Terhune, MD, Hopkinsville

FOURTH DISTRICT

BRECKINRIDGE

BULLITT

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GRAYSON

Gay Fulkerson, MD, Leitchfield

GREEN

William Shuffett, MD, Greensburg

HARDIN

Chris Godfrey, MD, Elizabethtown

Lucian Moreman, MD, Elizabethtown

Jeffrey Richardson, MD, Elizabethtown

HART

LARUE

MARION

Dan Hunt, MD, Lebanon

MEADE

NELSON

TAYLOR

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WASHINGTON

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Kenneth Anderson, MD, Louisville

Joseph Arterberry, MD, Louisville

William Baker, MD, Louisville

Arnold Belker, MD, Louisville

Susan M. Berberich, MD, Louisville

Charles Bisig, MD, Louisville

Steven Bloom, MD, Louisville

Mark Bronner, MD, Louisville

Mark Corbett, MD, Louisville

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Leah Dickstein, MD, Louisville

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Elmer E. Dunbar, MD, Louisville

John Ellis, MD, Louisville

Samuel Eubanks, MD, Louisville

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Julius T. Gavin, MD, Louisville

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Manuel Grimaldi, MD, Louisville

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Philip Hulsman, MD, Louisville

Walter Hume, Jr., MD, Louisville

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Ellen M. Joyce, MD, Louisville

Margie R. Joyce, MD, Louisville

Virginia Keeney, MD, Louisville

Stephen S. Kirzinger, MD, Louisville

Glenn Lambert, MD, Louisville

Renaro V. Larocca, MD, Louisville

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Gerlinda Lowrey, MD, Louisville

Michael Macfarlane, MD, Louisville

Charles Mahl, MD, Louisville

Thomas L. Matthew, MD, Louisville

Alice Minter-Sauer, MD, Louisville

Sean F. Murphy, MD, Louisville

David H. Neustadt, MD, Louisville

Daniel J. O'Brien, MD, Louisville

Vaughn W. Payne, MD, Louisville

Hobart L. Pence, MD, Louisville

Julio A. Ramirez, MD, Louisville

Steven J. Reiss, MD, Louisville

William M. Renda, MD, Louisville

Barton H. Reutlinger, MD, Louisville

Peter Ross, MD, Louisville

Melinda G. Rowe, MD, Louisville

G. Randolph Schrodt, Jr., MD, Louisville

G. Randolph Schrodt, Sr., MD, Louisville

Bruce A. Scott, MD, Louisville

Jerry Seligman, MD, Louisville

Monica A. Shaw, MD, Louisville

Rajesh K. Sheth, MD, Louisville

Victor J. Shpilberg, MD, Louisville

C. Steven Smith, MD, Louisville

Gerald Temes, MD, Louisville

Rebecca Terry, MD, Louisville

Alfred L. Thompson, MD, Louisville

Robert Tillett, MD, Louisville

Regulo Tobias, MD, Louisville

Brenda I. Townes, MD, Louisville

Molloy Veal, MD, Louisville

Kathy Vincent, MD, Louisville

Henry Walter, MD, Louisville

Stephanie P. Walton, MD, Louisville

G. Derek Weiss, MD, Louisville

Fred Williams, MD, Louisville

James A. Wright, MD, Louisville

C. Milton Young, MD, Louisville

Janice Yusk, MD, Louisville

George H. Zenger, MD, Louisville

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J. Mike Smith, MD, Glasgow

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CUMBERLAND

Joseph Skipworth, MD, Burkesville

EDMONSON

Omkar N. Bhatt, MD, Brownsville

LOGAN

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James E. Carter, MD, Tompkinsville

SIMPSON

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Samer Hussein, MD, Carrollton

FRANKLIN

Joseph Dobner, MD, Frankfort

Arba Kenner, MD, Frankfort

John M. Patterson, MD, Frankfort

GALLATI

GRANT

HOSS (Henry, Oldham, Shelby, Spencer counties)



David Jones, MD, Eminence
Brooks Jackson, MD, Shelbyville
Ron Walldridge, MD, Shelbyville
Kenneth Oder, MD, Taylorsville
OWEN
TRIMBLE
Winston Yap, MD, Bedford

EIGHTH DISTRICT

NORTHERN KY – (Boone, Campbell, Kenton counties)

Gordon Air, MD, Crestview Hills
Chris Bolling, MD, Crestview Hills
Dan Fagel, MD, Edgewood
Jim Farrell, MD, Crestview Hills
Allan Hallquist, MD, Edgewood
Michael Kirkwood, MD, Edgewood
Joe Martin, MD, Cold Spring
Kevin Martin, MD, Edgewood
Ross McHenry, MD, Edgewood
Ted Miller, MD, Edgewood
Neal Moser, MD, Crestview Hills
Richard Park, MD, Edgewood
Michael Robinson, MD, Edgewood
Bob Schwartz, MD, Edgewood
Steve Steinkamp, MD, Edgewood

NINTH DISTRICT

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BOURBON

Emmett Tate, MD, Paris

BRACKEN

FLEMING

HARRISON

Douglas Crutcher, MD, Cynthiana

MASON

NICHOLAS

Ana Rinaldini, MD, Carlisle

PENDLETON

ROBERTSON

SCOTT

TENTH DISTRICT

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James R. Bean, MD, Lexington
John W. Collins, MD, Lexington
Gerald V. Klim, MD, Lexington
Arthur Lieber, MD, Lexington
Wm. Dennis Newton, MD, Lexington
William N. O'Connor, MD, Lexington
Barbara Phillips, MD, Lexington
John W. Poundstone, MD, Lexington

F. Douglas Scutchfield, MD, Lexington
David B. Stevens, MD, Lexington
John D. Stewart II, MD, Lexington
JESSAMINE
Phyllis J. Corbitt, MD, Wilmore
WOODFORD

ELEVENTH DISTRICT

CLARK

Daniel Ewen, MD, Winchester

ESTILL

John A. Patterson, MD, Irvine

LEE

J. B. Noble, MD, Beattyville

JACKSON

MADISON

MONTGOMERY

MENIFEE

OWSLEY

POWELL

WOLFE

Paul Maddox, MD, Campton

TWELFTH DISTRICT

BOYLE

Brian Ellis, MD, Danville

Scott B. Scutchfield, MD, Danville

CASEY

CLINTON

Michael Cummings, MD, Albany

GARRARD

H. Mac Vandiviere, MD, Lancaster

LINCOLN

McCREARY

MERCER

George Noe, MD, Harrodsburg

PULASKI

ROCKCASTLE

Michael Hamilton, MD, Mt. Vernon

RUSSELL

H. Michael Oghia, MD, Columbia

WAYNE

THIRTEENTH DISTRICT

BOYD

George Aitken, MD, Ashland

Maurice Oakley, MD, Ashland

Roger Potter, MD, Ashland

Susan Prasher, MD, Ashland

Charles Watson, MD, Ashland

CARTER

ELLIOTT

GREENUP

LAWRENCE

Mark Kingston, MD, Louisa

LEWIS

MORGAN

George Bellamy, MD, West Liberty

ROWAN

Jane Wiczowski, MD, Morehead

FOURTEENTH DISTRICT

BREATHITT

FLOYD

James C. Campbell, MD, Prestonsburg

Nicholas Roger Jurich, MD, Prestonsburg

LETCHER

JOHNSON

KNOTT

Grady Stumbo, MD, Hindman

MAGOFFIN

MARTIN

PERRY

Mitch Wicker, MD, Hazard

Symala H.K. Reddy, MD, Hazard

PIKE

Gregory Hazelett, MD, Pikeville

Charles Nichols, MD, Pikeville

Mary Jo Ratliff, MD, Pikeville

J. Steven Shockey, MD, Pikeville

FIFTEENTH DISTRICT

BELL

Robert Gorrell, Jr., MD, Middlesboro

Emanuel Rader, MD, Pineville

CLAY

HARLAN

Sharon Colton, MD, Evarts

KNOX

Raymond Hayden, MD, Barbourville

LAUREL

LESLIE

WHITLEY

Bruce Barton, MD, Corbin

Bill Daniel II, MD, Corbin

Rod Weisert, MD, Corbin

KMA Student Section

UL – Beth Carlross, Louisville

UK – LaDonya Reed, Lexington

KMA Resident Physicians Section

Gene Wheeler, MD, Madisonville

REFERENCE COMMITTEE ACTIVITY

Speakers John W. McClellan, Jr, MD, Henderson, and Thomas K. Slabaugh, MD, Lexington, will assign all officers' and committees' reports and resolutions to one of five reference committees at the first meeting of the KMA House of Delegates at 10:00 AM, Monday, September 27, in the Regency Ballroom on the Lobby Level of the Hyatt Hotel in Lexington. A brief session for reference committee chairs will be held at 12:00 noon, Monday, in the San Francisco Room, located on the Mezzanine Level of the Hyatt Hotel. Any KMA member wishing to testify on any resolution or report is urged to be present for the reference committee meetings which will be held at

1:00 PM, Monday, September 27, in the Patterson meeting rooms on Lower Level B of the Hyatt Hotel. These open sessions will last at least one hour in order for all who wish to speak to be heard. Following the open hearings, the committees will go into executive session to study the reports, review the testimony, and write their reports to the House.

The committees' recommendations will be presented at the final meeting of the House, Wednesday evening, September 29, in the Patterson Ballroom, Hyatt Hotel.

The Speakers are now finalizing appointments for reference committees, the Credentials Committee, and Tellers. If your

society has not yet submitted the name of your delegate(s) to the Headquarters Office, you should do so immediately, as only those names recorded in the office can be considered for appointment to one of the reference committees and be listed as official county society representatives.

A listing of members who will be serving on the five reference committees, if completed, and the location of the reference committee meetings will be published in the September issue of the *KMA Journal*. Anyone desiring names of reference committee members before the September issue is published should contact the Headquarters Office.

MAKE YOUR RESERVATIONS NOW!

It is important that you begin to make your room reservations as soon as possible for the KMA Annual Meeting, September 27-30. The Hyatt Regency Lexington will be the Headquarters Hotel (Phone 606/253-1234). In making your reservations, remember the first House of Delegates meeting will be Monday, September 27. Be sure to make your reservation prior to September 1 and identify yourself as a KMA meeting attendee to receive the special convention rate---Single/Double-\$116.

RISK MANAGEMENT SEMINAR FOR OFFICE STAFF

"Something Old—Something New—Something Borrowed, So You Won't Get Sued"

Monday, September 27, 1999

9:00 am – 11:00 am

Hyatt Regency Lexington

Registration Deadline: Monday, September 20, 1999

This is a three-part program containing invaluable information **for the entire office staff**. The first part of the seminar focuses on the FAQs and just the FAQs! We've compiled a database of "Frequently Asked Questions" throughout the years and will share the answers with you during this informative session. Your most common questions pertaining to every aspect of risk management in the physician office will be covered from the receptionist's desk to the billing clerk's. You can expect to learn the intricacies of the medical records release laws as well as the right way to dismiss an angry, non-compliant patient with an outstanding balance, and much more.

The second part of this seminar will address fraud and abuse in the insurance arena. Items that will be discussed are "what is fraud and abuse," "civil and criminal penalties," and "what to do if you are investigated for fraud and abuse."

The third part of this seminar will address malpractice and the Internet. Did you know that attorneys are using this new technology to recruit potential malpractice clients? You'll find out how they are doing it and what you can do to protect yourself, your physician, and ultimately, the patient.

Cost: \$25.00 per staff member for Kentucky Medical's insured physician offices. \$50.00 per staff member for non-insured offices.

Premium Credit: KMIC-Insured physicians will receive a 3% premium credit on their next policy renewal if half of their office staff attends the program. (The maximum annual credit is 5% per physician.)

RISK MANAGEMENT SEMINAR FOR PHYSICIANS

Mistakes or Bad News: Delivery, Dialogue, and Dilemmas

Tuesday, September 28, 1999

12:00 pm – 2:30 pm

Hyatt Regency Lexington

Registration Deadline: Monday, September 20, 1999

This seminar is for physicians, physician assistants, and nurse practitioners. What should be done when a practitioner makes a mistake? Participants in this seminar will learn strategies for effectively dealing with patients when a mistake has been made. The concepts of admitting mistakes, and when apologies are appropriate are covered. The seminar also delineates strategies to use when bad or sad news must be conveyed to patients and family members.

Participants attending this seminar will:

- ♦ Learn differences between admitting mistakes and admitting negligence
- ♦ Clarify personal strategies for dealing with patients when a mistake has been made
- ♦ Acquire techniques to effectively deliver bad or sad news

Cost: \$50.00 per physician.

Premium Credit: Eligible KMIC physicians receive the maximum 5% risk management premium credit at their next applicable renewal for completing this seminar. Physicians not insured with KMIC will receive a voucher qualifying them for the maximum 5% premium credit when they place their professional liability insurance coverage with KMIC. (Subject to underwriting approval.)

CME Statement: Mutual Insurance Corporation of America (MICOA) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

MICOA/Kentucky Medical Insurance Company designates this continuing medical education activity for a maximum of 2 (two) hours in Category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

To request a registration form for the above seminars, call Risk Management Services at Kentucky Medical Insurance Company either toll-free at 1-800-467-1858 or in Louisville at 339-5741. To register on line, or for more information about other seminar dates, visit our website at www.micoa.com.



1999 KMA ANNUAL MEETING HONORS PAST PRESIDENT PHILIP H. STEWART, MD

The 1999 Annual Meeting of the Kentucky Medical Association will be officially titled "The P. H. Stewart Meeting" in remembrance of the 1917 President of the Association. The tradition of honoring a past president of KMA and other distinguished physicians originated with the 1935 Annual Meeting. Eugene H. Conner, MD, Louisville, KMA Historian, has written a biography on Dr Stewart that begins on the next page.

SCIENTIFIC SESSIONS are scheduled for Tuesday and Wednesday, at the Lexington Center in Lexington. The theme for the 1999 scientific session is "Health Care Alternatives." Both the presentations and discussion periods will contribute to the continuing medical education of Kentucky's physicians.

TWENTY-ONE SPECIALTY GROUPS will hold meetings on September 28 and 29 beginning at 1:30 PM on Tuesday and 2:15 PM on Wednesday. Individual programs of specialty societies and meeting locations are listed in this issue. All general sessions will be held in the mornings. Specialty groups will meet both days with no general sessions scheduled during these specialty group meetings. All KMA members are invited to attend any specialty meetings.

SCIENTIFIC AND TECHNICAL EXHIBITS will display new medical products, services, and techniques in the Exhibit Hall, located in the Lexington Center during the 1999 Annual Meeting. Members



HEALTH CARE ALTERNATIVES

KMA Annual Meeting
Sept 27 - 30
Hyatt Regency/Lexington Center
Lexington, Kentucky

and guests are urged to take the opportunity to view products of interest at the 30-minute intermissions scheduled during each general and specialty session.

THE KMA HOUSE OF DELEGATES will meet twice during the Annual Meeting. The first meeting of the House will be held at 10:00 AM, Monday, September 27, in the Regency Ballroom located in the Hyatt Hotel. The final meeting will be held Wednesday, September 29, at 7:00 PM, in the Patterson Ballroom. Officers for the 1999-2000 Association year will be elected at the second meeting.

THE PRESIDENT'S INSTALLATION & AWARDS LUNCHEON will be held on Wednesday, September 29, in the Patterson Ballroom located in the Hyatt Hotel. The luncheon will include the presentation of KMA awards and the installation of the 1999-2000 President, Harry W. Carloss, MD, Paducah.



PHILIP H. STEWART, MD [1867-1934]

During the KMA Annual Meeting in Louisville, KY, on November 6, 1917, Philip H. Stewart, MD, presided as its 62nd President. At that time, the world was in turmoil as WWI raged in Europe. The US had declared war on Germany on 6 April 1917. Mobilization of troops had begun and physicians had volunteered for service in the Medical Reserve Corps (MRC). Many had already joined troops on active duty at home and abroad; therefore, the time and location of the KMA meeting had been changed from its usual September dates to 6-9 November to allow the Medical Reservists in Kentucky to respond to the War Department order that all members of Examining Boards of the MRC attend a meeting of the Congress of Clinical Surgeons in Chicago.¹

Topics addressed at this wartime meeting of KMA, described by former KMA Secretary J. N. McCormick, MD, as a "great military picture symposium,"² necessarily focused upon medical problems being addressed by military surgeons. There were two presentations by Captain George(s) Loewy³ of the French Army Medical Service, who demonstrated the treatment of war wounds by the Carrel-Dakin (C-D) method and gave a lecture illustrated by Lumiere colored plates showing the remarkable results achieved by use of the C-D treatment of infected wounds.⁴ Transportation of the wounded and demonstrations of methods of defense against effects of gas attacks were also part of the scientific program.

Doctor Stewart was born December 24, 1867 near Salem in Livingston County, KY, the son of W. W. Stewart [b. 1818].⁵ The family moved to

Smithland, the county seat of Livingston County, when he was quite young. After completing the standard course at the Normal School in Madisonville, KY, in 1886, he went west where he worked as a bookkeeper and clerk.⁶ Returning home the following year he became a student of medicine in the office of Henry H. Duley, MD.^{7,8}

Stewart enrolled in the University of Louisville Medical Department for the sessions of 1888-89 and 1889-90 receiving his MD in March 1890, afterward beginning practice in Paducah, McCracken County, KY. As his practice grew he soon focused upon the treatment of patients with disorders requiring surgery. In 1893, he attended a postgraduate course in surgery in New York City and again in 1901 another course in surgery in Chicago. What schools he attended and the duration have not been determined, but he developed a reputation among his peers as a successful, conservative surgeon with a particular interest in orthopedics. He is credited at the time of his death with having performed the first operation in Paducah for acute appendicitis. Although no date was given for the operation, it was an indication of his awareness of early diagnosis and prompt operative intervention to save the life of the patient showing signs of an acute intraabdominal disease. This was such a momentous operation at the time, that his assistants in surgery, his physician anesthetist and his patient's name were still well known about 40 years later.⁹

Doctor Stewart practiced with his business partner E. W. Jackson, MD, from their offices in the City

National Bank building in Paducah. He practiced at the Riverside Hospital where he was President of the Medical Staff at the time of his death.¹⁰

An active participant in the state regional and local medical societies, he served as President of KMA (1917), Southwest Kentucky Medical Society (1901) and several times in that office for the McCracken County Medical Society. He was also President of the "Walnut Log Medical Society,"¹¹ and was a charter member of the American College of Surgeons.

Doctor Stewart continued to participate in discussions of medical papers at the KMA Annual Meetings until late 1923. He presented papers or presided at many meetings of medical societies, but his publications appear to have been limited to his "President Address,"¹² in which his observations on medical education concerned the decrease in the number of physicians resulting from the higher standards of medical schools and elevated entrance requirements.

An interesting resolution was presented to the McCracken County Medical Society by Dr Stewart on 24 May 1917, as 21 members met in Paducah. This resolution was twofold; "members of the Medical Society offered their services to the United States of America and they pledge to attend to the professional duties of members called to active duty and to give one third of such collections to their families."¹³ How this resolution was implemented is not further stated!

Stewart was married to Miss Lillie E. Hobson in 1890. Two sons, Herbert W. and John H., were born to this marriage, but neither are mentioned as surviving their father.

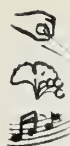
Stewart's own military service was begun at Camp Taylor, Louisville, KY, and continued at Camp Holabird, Baltimore, MD. He was promoted to Lt. Colonel when he was discharged from active service.

Doctor Stewart was a well known general surgeon whose term as KMA President-Elect and President coincided with the US entering WWI and the mobilization of numerous troops and Medical Reserve units. His medical and administrative talents, readily recognized, were widely utilized in civilian as well as military service.

Eugene H. Conner, MD
KMA Historian

REFERENCES

1. Notice "Our Association meets November 6-9, in Louisville." *KMJ* 15, 451 (Oct) 1917.
2. Ibid. Editorial [J. N. McCormick, MD] "Great Military Picture Symposium for the Annual Meeting." *KMJ* 15, 498-99 (Dec) 1917.
3. Captain Georges Loewy [b. 1884], was from the French Army Medical Services and Assistant to Alexis Carrel, MD, War Demonstration Hospital, Rockefeller Foundation, New York, formerly Assistant to Professor Tuffler; Hôpital Beaujou; Paris, France.
4. Loewy, Capt. George "Treatment of infected wounds—Dr. Carrel's Technique." *KMJ* 16, 63-67 (Feb) 1918.
5. Johnson, E. Polk, Editor. *History of Kentucky and Kentuckians*, 3, 1290, 1912.
6. Goodlloe, ER., W. B. Willingham, Leon Higdon and Allen Shemwell, Memorial to Dr. P. H. Stewart. *KMJ* 33, 47-48 (Jan) 1935.
7. *Catalogue University of Louisville Medical Department, 1890-1891*. J. P. Morton & Co., Louisville, KY, 1890, p21.
8. Henry H. Duley, MD [1841-1927] a graduate of Cincinnati College of Medicine and Surgery 1881, practiced in Smithland, KY, and has been identified as P. H. Stewart's preceptor in Medicine.
9. "Illness of 3 weeks fatal to Dr. Stewart," *Paducah Sun Democrat*, Paducah, KY, 57, No. 24 Monday Evening October 8, 1934. p1 col [1] & p7 col [8].
10. Ibid. and *Paducah Sun Democrat*, Paducah, KY., 57, No 25 Tuesday Evening October 9, 1934. Editorial p4 col [1] and p4 cols [3-4].
11. Deaths. *JAMA* 103, 1467 (10 Nov) 1934.
12. Stewart, P. H., Major MRC, Paducah, President's Address, "The Trend of Medical Education."
13. McCracken County Medical Society, President J. B. Acree presiding. *KMJ* 15, 357 (July) 1917.

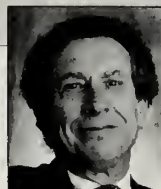


INTRODUCING THE GUEST SPEAKERS



GASTROENTEROLOGY

Todd H. Baron, MD
Rochester, MN
Senior Associate Consultant; Associate Professor, Dept of Medicine, Division of Gastroenterology & Hepatology, Mayo Clinic, Rochester, MN.



ALLERGY & CLINICAL IMMUNOLOGY

Robert E. Reisman, MD
Buffalo, NY
Clinical Professor of Medicine/Pediatrics, State University of New York at Buffalo; Attending Allergist, Dept of Pediatrics, Allergy Division, Children's Hospital of Buffalo.



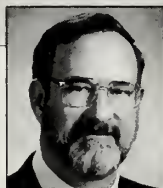
PLASTIC & RECONSTRUCTIVE SURGERY

Charles L. Puckett, MD
Columbia, MO
Vice Chair, Dept of Surgery, and Professor of Plastic Surgery, University of Missouri-Columbia; Vice Chair, Dept of Surgery, Harry S. Truman Veteran's Hospital and Boone Hospital Center.



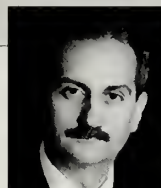
DERMATOLOGY

Jay M. Kincannon, MD
Little Rock, AR
Associate Professor of Pediatrics and Dermatology, University of Arkansas for Medical Sciences; Chief of Pediatric Dermatology, Arkansas Children's Hospital.



COLLEGE OF PHYSICIANS

W. James Stackhouse, MD
Goldsboro, NC
Partner, Goldsboro Medical Specialists; Chairman of the Board, Atlantic Integrated Health.



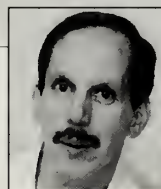
EYE PHYSICIANS & SURGEONS

Jose S. Pulido, MD
Chicago, IL
Head and Professor, Department of Ophthalmology and Visual Science, University of Illinois at Chicago. Director, Diabetes 2000.



KY SECTION ACOG

Susan M. Cox, MD
Dallas, TX
Assistant Dean, Professional Education; Associate Professor, Ob/Gyn; Director, Maternal-Fetal Medicine Fellowship, University of Texas Southwestern Medical Center, Dallas.



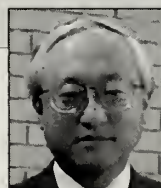
COLLEGE OF SURGEONS

Andrew B. Peitzman, MD
Pittsburgh, PA
Professor of Surgery and Director, Trauma & Surgical Critical Care, and Chief, Division of General Surgery, University of Pittsburgh School of Medicine; Director, Trauma Services, University of Pittsburgh Trauma Services.



PHYSICAL MEDICINE & REHABILITATION

Ann C. Cotter, MD
Morristown, NJ
Assistant Professor of Clinical Physical Medicine & Rehabilitation, New Jersey Medical School; UCLA School of Medicine, CME Division: Preceptor for Acupuncture for Physicians Course.



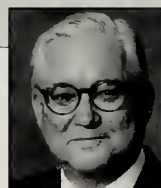
PSYCHIATRY

Kenneth M. Sakauye, MD
New Orleans, LA
Professor of Clinical Psychiatry, LSU Medical Center; Director, Geriatric Psychiatry, LSU Medical School, New Orleans.



FAMILY PHYSICIANS

Daniel I. Kaufer, MD
Pittsburgh, PA
Assistant Professor, Neurology and Psychiatry, University of Pittsburgh School of Medicine; Director, Dementia Treatment Program, Alzheimer's Disease Research Center, Pittsburgh.



ORTHOPAEDICS

Edward H. Miller, MD
Cincinnati, OH
Clinical Professor of Orthopaedic Surgery, University of Cincinnati College of Medicine. Associate Director, Bone and Joint Institute, The Christ Hospital, Cincinnati.



GERIATRICS

James G. O'Brien, MD
Prospect, KY
Margaret D Smock Endowed Chair in Geriatrics, University of Louisville, Dept of Family & Community Medicine.



NEUROSURGEONS

L. Nelson Hopkins, MD
Buffalo, NY
Dept of Neurosurgery; Professor and Chair of Neurosurgery; Professor of Radiology, State University of NY at Buffalo.



COMMONWEALTH NEUROLOGICAL

William C. Koller, MD
Miami, FL
Professor, Department of Neurology, University of Miami; National Research Director, National Parkinson Foundation, Miami.



(Photo not available)

EMERGENCY PHYSICIANS

Daniel C. Keyes, MD
Dallas, TX
Chief, Section of Toxicology, Division of Emergency Medicine, and Assistant Professor, Internal Medicine, UT Southwestern School of Medicine, Dallas.



(Photo not available)

PEDIATRICS

Gerald B. Hickson, MD
Nashville, TN
Chief, Division of General Pediatrics, and Professor, Dept of Pediatrics, Vanderbilt University School of Medicine.



(Photo not available)

PUBLIC HEALTH

Glyn G. Caldwell, MD
Frankfort, KY
Director, Division of Epidemiology & Health Planning, Dept for Public Health.



GENERAL SESSIONS LEARNING OBJECTIVES

KY CHAPTER, AMERICAN
COLLEGE OF PHYSICIANS-
AMERICAN SOCIETY OF
INTERNAL MEDICINE
***Dealing with the Alternatives in
Primary Care***

W. James Stackhouse, MD

The objectives are to improve understanding of the "roots" and appeal of alternative medicine to patients; to broaden the physician's understanding, and acceptance, of alternative medicine choices by patients, and facilitate discussions with patients; and to offer ways of approaching patients about their use of alternative medicines.

KY SOCIETY OF ALLERGY,
ASTHMA, AND CLINICAL
IMMUNOLOGY
***Insect Sting Allergy – Diagnosis
and Treatment***

Robert E. Reisman, MD

The objectives are to be aware of the various reactions that occur as a result of insect stings and bites; to be familiar with the indications for and types of diagnostic testing which are useful for people who have had reactions from insect bites; and to be familiar with the indication for and types of therapy for people who have had insect sting reactions.

KY SOCIETY OF
GASTROINTESTINAL ENDOSCOPY
***The Use of Expandable Metal
Stents for the Treatment of Malignant
Gastro-duodenal and Colonic
Obstruction***

Todd H. Baron, MD

The objective of this lecture is to describe the indications, techniques, and outcomes for the use of expandable metal stents in treating malignant obstruction of the gastrointestinal tract outside the esophagus and biliary tree.

KY CHAPTER, AMERICAN
ACADEMY OF FAMILY
PHYSICIANS
***Treatment Issues in Alzheimer's
Disease***

Daniel I. Kaufer, MD

The objectives are to discern the two major types of treatment for Alzheimer's disease, symptomatic and neuroprotective, and understand their complementary nature; to define realistic goals for current Alzheimer's Disease therapies, and how to assess them; and to discuss safety and efficacy issues surrounding over-the-counter remedies used to treat Alzheimer's disease.

KY CHAPTER, AMERICAN
COLLEGE OF SURGEONS
***Changing Concepts in Initial Re-
suscitation of the Trauma Patient***

Andrew B. Peitzman, MD

The objectives are to understand appropriate priorities in the management of the multiply injured patient; to discuss controversies in fluid resuscitation of the trauma patient; to discuss endpoints in volume resuscitation of the trauma patient; and to discuss role of blood transfusion in the treatment of the trauma patient.

KY PEDIATRIC SOCIETY
***Managed Competition: A Failing
System for Medicaid***

Gerald B. Hickson, MD

As a result of attendance, participants should understand state motivations for changing traditional Medicaid programs; differences between managed care and managed competition; performance of TennCare as a managed competition prototype including failures of access, outcomes, and financing; and strategies for avoiding such "Grand Experiments."

KY SECTION, AMERICAN
COLLEGE OF OBSTETRICIANS
AND GYNECOLOGISTS
Alternative Birth: If Dolphins Do It!
Susan M. Cox, MD

The objectives are to understand alternative birth methods such as squatting, Walcher's position and warm water immersion; list the benefits of warm water births; and recite the risks of warm water births.

KY DERMATOLOGICAL SOCIETY
***Management of Hemangiomas in
Children***

Jay Kincannon, MD

The objective of this lecture is to increase the physician's knowledge of the classification and advances in medical, surgical, and laser treatment options in treating hemangiomas in children.

KY GERIATRICS SOCIETY
Healthy Aging

James G. O'Brien, MD

The objectives are to provide an overview of aging in the next millennium; to present strategies that enhance health in aging; and to review preventive strategies in aging.

KY CHAPTER, AMERICAN
COLLEGE OF EMERGENCY
PHYSICIANS
***The Toxic Garden: A Review of
Herbal Poisonings***

D. Christopher Keyes, MD, MPH

The participant will be able to identify commonly used herbs which can become toxic, drug interactions of prescription medications and commonly used herbs, and diagnostic studies to recognize herbal toxicity.

KY ACADEMY OF EYE
PHYSICIANS AND SURGEONS
Nonsurgical Management of Diabetic Retinopathy

Jose S. Pulido, MD

The objectives are to learn the results of the DCCT and UKPDS, and to learn other local and systemic diseases that can affect the development of diabetic retinopathy.

KY SOCIETY FOR PLASTIC &
RECONSTRUCTIVE SURGERY
Digital Photography: Applications for Plastic Surgery

Charles L. Puckett, MD

The objective of this session is to have a better understanding of the values and various applications of digital photography in plastic surgery and medicine in general.

KY PSYCHIATRIC ASSOCIATION
Cultural Issues in Psychiatry

Kenneth Sakauye, MD

Through examples from the use of several common tests such as the MMSE, the participant will understand common differences in test responses based on cultural influences; know the definition and importance of "ethnocentric bias" in misinterpreting behavior; and learn selective facts on differences in rates of psychopathology and dementia as well as medication effects due to racial differences.

COMMONWEALTH
NEUROLOGICAL SOCIETY

New Treatment in Treating Tremors: Parkinsonian & Essential Tremors

William C. Koller, MD, PhD

The objectives of this session are to be able to make the diagnosis of Parkinson's disease; to understand pharmacological therapy for Parkinson's disease; and to appreciate surgical options in Parkinson's disease.

KY ORTHOPAEDIC SOCIETY
Intra-Articular Hyaluronic Acid Therapy for Osteoarthritis of the Knee

Edward H. Miller, MD

Physicians will understand the basic science of Intra-Articular Hyaluronic Acid Therapy for osteoarthritis of the knee, and the results of clinical trials of HA in the treatment of OA of the knee. Physicians will be able to screen and select patients who qualify for the HA treatment; will understand the side effects of the treatment; and will learn about new treatments under trial at the present time.

KY NEUROSURGICAL
SOCIETY

Carotid Revascularization: Alternatives to Endarterectomy in High Risk Patients

L. N. Hopkins, MD

The objective for this session is to understand patient selection for carotid artery stenosis, pre and post op management, technique, and results of treatment.



1999 KMA ANNUAL MEETING

Scientific Program

Philip H. Stewart, MD, Meeting

Tuesday, September 28

Donald R. Stephens, MD KMA President, Presiding

General Sessions Area
Lexington Center

- 8:30 AM **Welcome and Announcements**
8:40 AM **Intra-Articular Hyaluronic Acid Therapy for Osteoarthritis of the Knee**
Edward H. Miller, MD, Cincinnati, Ohio
Kentucky Orthopaedic Society
9:00 AM **Cultural Issues in Psychiatry**
Kenneth Sakauye, MD, New Orleans, Louisiana
Kentucky Psychiatric Association
9:20 AM **NonSurgical Management of Diabetic Retinopathy**
José S. Pulido, MD
Kentucky Academy of Eye Physicians and Surgeons
9:40 AM **Digital Photography: Applications for Plastic Surgery**
Charles L. Puckett, MD, Columbia, Missouri
Kentucky Society of Plastic and Reconstructive Surgeons
10:00 AM **Intermission to visit exhibits**
10:30 AM **The Toxic Garden: A Review of Herbal Poisonings**
D. Christopher Keyes, MD, Dallas, Texas
Kentucky Chapter, American College of Emergency Physicians
10:50 AM **Carotid Revascularization: Alternatives to Endarterectomy in High-Risk Patients**
L. N. Hopkins, MD, Buffalo, NY
Kentucky Neurosurgical Society
11:10 AM **Dealing with the Alternatives in Primary Care**
W. James Stackhouse, MD, Goldsboro, NC
Kentucky Chapter, American College of Physicians-American Society of Internal Medicine
11:30 AM **Changing Concepts in Initial Resuscitation of the Trauma Patient**
Andrew B. Peitzman, MD, Pittsburgh, Pennsylvania
Kentucky Chapter, American College of Surgeons
11:50 AM **Adjourn**

KY Chapter, American College of Surgeons

Lexington Center
Ballroom 4 - General Sessions Area
Tuesday, September 28

- 1:30 PM **Blunt Abdominal Trauma: The Rules Keep Changing**
Andrew B. Peitzman, MD, FACS, Guest Speaker
2:15 PM **TBA**
Eric Bentley, MD
2:20 PM **Trauma Ultrasound in the New Millennium**
Bernard Boulanger, MD
2:40 PM **Sepsis and Organ Failure Approaches to Therapy: A Challenge for the New Millennium**
William Cheadle, MD
3:00 PM **Intermission to visit exhibits**
3:15 PM **Why Has Biotechnology Failed in the Treatment of Sepsis?**
Paul Kearney, MD
3:35 PM **ARDS**
David Spain, MD
3:55 PM **New Insights into Trauma Induced Immune Suppression**
Andrew Bernard, MD
4:15 PM **TBA**
Eddy Carrillo, MD
4:35 PM **Summary and Adjournment**
Juan Ochoa, MD

KY Chapter, American College of Emergency Physicians

Lexington Center
Meeting Room F
Tuesday, September 28

- 1:30 PM **The Toxic Garden: A Review of Herbal Poisonings**
D. Christopher Keyes, MD, MPH
2:30 PM **Adjourn**

KY Academy of Physical Medicine and Rehabilitation

Lexington Center
Meeting Room D
Tuesday, September 28

- 1:00 PM **Business Meeting**
- 1:30 PM **The Use of Accupuncture in Rehabilitation
Medicine: An Overview**
Ann C. Cotter, MD
- 2:30 PM **Resident Presentations**
- 4:00 PM **Adjourn**

KY Neurosurgical Society

Lexington Center
Meeting Room E
Tuesday, September 28

- 1:00 PM **Intracranial Atherosclerosos and "Inoperable
Aneurysms": New Approaches to Difficult Problems**
L. N. Hopkins, MD
- 2:00 PM **Recent Preclinical Advances in Spinal Cord Injury**
Scott R. Whittemore, PhD
- 2:25 PM **Neuronavigation and Intraoperative Operative MRI**
Thomas M. Moriarty, MD, PhD
Paul Larson, MD
- 2:50 PM **Cerebral Lactate and Free Fatty Acids After
Subarachnoid Hemorrhage**
Robert Gewirtz, MD
Steve Scheff, PhD
- 3:15 PM **MRI vs Milography in Determination of Fusion
Levels in Spinal Stenosis**
T. R. Vitaz, MD
S. G. Glassman, MD
G. H. Raque, MD
- 3:35 PM **Treatment of Trigeminal Neuralgia with Gamma
Knife Radiosurgery**
Brad Nicol, MD
William Regine, MD
Byron Young, MD
- 4:00 PM **Early Experience with Thalamic Deep Brain
Stimulation for Tremor**
Nathan Avery, MD
Byron Young, MD
- 4:45 PM **Business Meeting and Election of Officers**
- 5:15 PM **Adjourn**

KY Academy of Eye Physicians and Surgeons

Lexington Center
Ballroom 2
Tuesday, September 28

- 1:30 PM **Surgical & NonSurgical Treatment of Diabetic
Retinopathy**
Josè S. Pulido, MD
- 2:15 PM **TBA**
- 2:45 PM **Intermission to visit exhibits**
- 3:15 PM **Endophthalmitis**
Josè S. Pulido, MD
- 4:00 PM **TBA**
- 4:45 PM **KAEPS Business Meeting**
- 5:30 PM **Adjourn**

KY Society for Plastic and Reconstructive Surgery

Lexington Center
Meeting Room B
Tuesday, September 28

- 1:30 PM **Senior Resident Paper – TBA**
Brian Kiesnowski, MD
- 1:45 PM **Senior Resident Paper – TBA**
Jason Arrington, MD
- 2:00 PM **Repair of Groin Lymphoceles Using Intra-
Operative Blue Dye Lymphatic Mapping**
Wayne K. Stadelmann, MD
Frank Miller, MD
Gordon R. Tobin, MD
- 2:15 PM **Resident Paper – TBA**
Monsour Shirbacheh, MD
- 2:45 PM **Updates in Hand Transplants**
Gordon R. Tobin, MD
- 3:00 PM **ASPRS Update**
Charles L. Puckett, MD
- 3:30 PM **Adjourn**

KY Orthopaedic Society

Lexington Center
Ballroom 3
Tuesday, September 28

- 1:30 PM **Welcoming Comments and Business Meeting**
Donald L. Pomeroy, MD, President
- 1:35 PM **Analysis of the Results of Viscosupplementation with Hylan G-F 20 in the Treatment of Osteoarthritis of the Knee – A Prospective Study of 108 Patients**
Edward H. Miller, MD
- 2:05 PM **The Biomechanical Aspects of External Fixator Application**
Peter M. Murray, MD
- 2:20 PM **Outcome of Arthroscopic Synovectomy for Adhesive Capsulitis of the Shoulder**
Patrick Bauer, MD
- 2:35 PM **Bioabsorbable Fixation for Trauma Surgery**
David Seligson, MD
- 2:50 PM **A Comparison of Failed and Successful Shoulder Arthroplasties and the Management of Failure**
Michael J. Moskal, MD
- 3:05 PM **Intermission to visit exhibits**
- 3:25 PM **Comparison of Functional Results in Patients with Inter-Articular Distal Radius Fractures Treated with Anatomic vs. Anon-Anatomic Fixation**
Jeff Davila, MD
- 3:40 PM **Posterior Cruciate Ligament Insufficiency and Meniscal Bearing Total Knee Replacement: In Vivo Kinematic Analysis**
Daxes Banit, MD
- 3:55 PM **Operative Fixation for Displaced Sternal Fractures; An Under-Utilized Treatment Modality**
Kittie George, MD
- 4:10 PM **Quantification of Tendon Slippage in ACL Reconstruction**
Eric S. Steenlage, MD
- 4:25 PM **Report of 13 Patients Treated with Open Door Laminoplasty for Cervical Spondylitic Myelopathy**
Mitchell J. Campbell, MD
- 4:40 PM **Posterior Cruciate Ligament Reconstruction with Central Third Quadriceps Tendon**
Mike Lauffenburger, MD
- 4:55 PM **The Initial Clinical Experience with the Osteo Compression Intramedullary Nail**
Ty Richardson, MD
- 5:10 PM **Comparison of Subtrochanteric Femur Fracture Fixation Strength**
Robert A. Morgan, MD
- 5:25 PM **Report from American Academy of Orthopaedic Surgeons**
K. Thomas Reichard, MD
- 5:35 PM **Report from Kentucky Medical Association**
John Burch, MD
- 5:40 PM **Adjourn**
- 6:30 PM **Reception – Emmett's Restaurant, 1097 Duvall Street (off Tate's Creek Road), Lexington)**
- 7:00 PM **Dinner – Emmett's Restaurant**

KY Psychiatric Association

Lexington Center
Meeting Room A
Tuesday, September 28

- 1:30 PM **Cross Cultural Issues in Mental Health**
Kenneth Sakauye, MD
- 2:30 PM **Intermission to visit exhibits**
- 3:00 PM **Complementary and Alternative Therapies in Psychiatry**
Randolph Schrodt, MD
- 4:00 PM **General Meeting**
- 4:30 PM **Adjourn**

KY Chapter, American College of Physicians-American Society of Internal Medicine

Lexington Center
Meeting Room C
Tuesday, September 28

- 1:00 PM **Registration**
- 1:10 PM **Introductions**
Joseph G. Weigel, MD, FACP
- 1:15 PM **Associate Presentations**
- 2:15 PM **ACP-ASIM Update**
W. James Stackhouse, MD, FACP
- 2:45 PM **Intermission to visit exhibits**
- 3:15 PM **Infectious Disease Case Vignettes-Diagnosis and Management**
William Dismukes, MACP
- 3:40 PM **The Common Plagues – Are We Ready?**
Claire Pomeroy, MD
- 4:05 PM **Antibiotic Resistant Organism – The Future Meeting the Past**
Anna K. Huang, MD
- 4:30 PM **Infectious Disease & Human Evolution**
Daniel Rodrigue, MD
- 5:00 PM **Adjourn**
- 6:00 PM **Cocktails & Dinner – Hyatt, Kentucky Room**
After Dinner Talk – John Furcolow, MD
- 7:00 PM **Town Meeting**
W. James Stackhouse, MD, FACP
Elizabeth Prewitt, Director, ACP-ASIM
Washington Office

Note: The following Specialty Group meetings will be held in the Hyatt Regency Hotel, directly across the mall from Lexington Center, same level.

KY Association of Public Health Physicians

Hyatt Regency Hotel
Patterson E, Lower Level B
Tuesday, September 28

- 1:30 PM **Effects of the Nuclear Weapons Program on the United States**
Glyn G. Caldwell, MD
- 3:00 PM **Adjourn**

KY Chapter, American Society of Addiction Medicine

Hyatt Regency Hotel
Patterson F, Lower Level B
Tuesday, September 28

- 1:30 PM **Annual Meeting**
Speakers to be announced

President's Installation & Awards Luncheon

Wednesday, September 29, 1999, 11:50 am
Patterson Ballroom - Hyatt Regency Hotel

Donald R. Stephens, MD
KMA President, Presiding

Awards Presentation
Richard F. Hench, MD
Chair, Awards Committee

Installation of
Harry W. Carloss, MD
KMA President 1999-2000

Wednesday, September 29

James L. Borders, MD, Chair Scientific Program Committee, Presiding

General Sessions Area
Lexington Center

- 8:30 AM **Welcome and Introductions**
- 8:40 AM **Managed Competition: A Failing System for Medicaid**
Gerald B. Hickson, MD, Nashville, Tennessee
Kentucky Pediatric Society
- 9:00 AM **TBA**
Kentucky Society of Anesthesiologists
- 9:20 AM **The Use of Expandable Metal Stents for the Treatment of Malignant Gastroduodenal and Colonic Obstruction**
Todd H. Baron, MD, Rochester, Minnesota
Kentucky Society for Gastrointestinal Endoscopy
- 9:40 AM **Insect Sting Allergy - Diagnosis and Treatment**
Robert E. Reisman, MD, Williamsville, New York
Kentucky Society of Allergy, Asthma, and Clinical Immunology
- 10:00 AM **Intermission to visit exhibits**
- 10:30 AM **Alternative Birth: If Dolphins Do It?**
Susan M. Cox, MD, Dallas, Texas
Kentucky Section, American College of Obstetricians & Gynecologists
- 10:50 AM **Treatment Issues in Alzheimer's Disease**
Daniel I. Kaufer, MD, Pittsburgh, Pennsylvania
Kentucky Chapter, American Academy of Family Physicians
- 11:10 AM **New Treatment in Treating Tremors: Parkinsonian & Essential Tremors**
William C. Koller, MD, PhD, Miami, Florida
Commonwealth Neurological Society
- 11:30 AM **Adjourn**

Commonwealth Neurological Society

Lexington Center
Meeting Room C
Wednesday, September 29

- 2:15 PM **New Treatments in Movement Disorders**
William C. Koller, MD, PhD*
- 3:15 PM **Business Meeting**

**An educational grant has been provided by Medtronic Neurological for Dr William Koller's presentation.*



KY Society of Allergy, Asthma, and Clinical Immunology

Lexington Center
Ballroom 2
Wednesday, September 29

- 2:15 PM **Update on Insect Allergy**
Robert E. Reisman, MD
- 3:00 PM **Latex Update**
Arun Wapambi, MD
- 3:30 PM **Business Meeting**
- 3:45 PM **Adjourn**

KY Dermatological Association

University of Kentucky - Kentucky Clinic
Lexington, Kentucky
Wednesday, September 29

- 11:30 AM **Registration** - 5th Floor Foyer, KY Clinic
- 12:00 PM **Business Meeting** - J524, 5th Floor, KY Clinic
- 12:30 PM **Registration** - 2nd Floor General Internal
Medicine Clinic
- 1:00 PM **Patient Viewing** - 2nd Floor General Internal
Medicine Clinic
- 2:00 PM **Break**
*Go to Hospital Auditorium, H611, 6th Floor,
University Hospital*
- 2:15 PM **CLIA Testing**
- 2:30 PM **Management of Hemangiomas in Children**
Jay Kincannon, MD
- 3:20 PM **Break**
- 3:30 PM **Case Discussions**
- 5:30 PM **Cocktails & Dinner** - UK Faculty Club

KY Occupational Medical Association

Lexington Center
Meeting Room B
Wednesday, September 29

- 2:15 PM **Occupational Medicine and Chiropractic Care**
Craig Mueller, DC
- 2:45 PM **The Use of Magnets to Treat Pain**
Mary Carney, RN
- 3:10 PM **Adjourn**

KY Academy of Family Physicians / KY Geriatrics Society

Lexington Center
Ballroom 3
Wednesday, September 29

- 2:15 PM **Diagnosis and Treatment of Alzheimer's
Disease in Primary Care Settings**
Daniel I. Kaufer, MD
- 3:00 PM **Intermission to visit exhibits**
- 3:30 PM **Healthy Aging**
James G. O'Brien, MD
- 4:30 PM **KY Academy of Family Physicians Adjourn**
- 4:30 PM **KY Geriatric Society Business Meeting**

KY Society for Gastrointestinal Endoscopy

Lexington Center
Meeting Room A
Wednesday, September 29

- 1:30 PM **Welcome**
- 1:40 PM **Use of Expandable Stents in the GI Tract**
Todd H. Baron, MD
- 2:25 PM **Scientific Presentations**
- 3:15 PM **Business Meeting**
*Move to Hyatt Regency, Kentucky Room, Lower
Level A, for Coding Seminar*
- 3:30 PM **Intermission to visit exhibits**
- 4:00 PM **Coding Seminar**
Mark Painter, Physician Reimbursement Systems,
Denver, CO
- 8:00 PM **Adjourn**

KY Pediatric Society

Lexington Center
Meeting Room E
Wednesday, September 29

- 2:15 PM **Managed Competition: A Failing System for
Medicaid**
Gerald B. Hickson, MD
- 3:00 PM **Intermission to visit exhibits**
- 3:30 PM **Questions**
- 3:45 PM **Adjourn**

KY Section, American College of Obstetricians & Gynecologists

Lexington Center
Ballroom 4 - General Sessions
Wednesday, September 29

- 1:30 PM **Herbs in Obstetrics: The Good, the Bad, and the Ugly**
Susan M. Cox, MD
- 2:15 PM **Alternative Therapies to Cancer Care**
Steven H. Pursell, MD
- 2:45 PM **Intermission to visit exhibits**
- 3:15 PM **Alternatives in Menopausal Management**
Jamie Akin, MD
- 3:45 PM **Managing the Pelvic Floor without Surgery**
Fred Ueland, MD
- 4:15 PM **Adjourn**

KY Society of Anesthesiologists

Lexington Center
Meeting Room D
Wednesday, September 29

- 2:15 PM **TBA**

COLLECTIVE BARGAINING FOR PHYSICIANS - WHAT YOU CAN AND CAN'T DO

Sponsored by the Kentucky Medical Association

MONDAY, SEPTEMBER 27, 1999
3:00 PM - 4:00 PM
ATLANTA ROOM, HYATT

Presented by Charles J. Cronan IV, Esquire

Physicians of Indian Origin and All International
Medical Graduates/Students in Kentucky

PLEASE ATTEND THE RECEPTION/MEETING WITH
KMA PRESIDENT, HARRY W. CARLOSS, MD
WEDNESDAY, SEPTEMBER 29, 1999
4:30 PM

LOCATION: PATTERSON H - HYATT REGENCY LEXINGTON

Continuing Medical Education

The Kentucky Medical Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The Kentucky Medical Association designates this educational activity for a maximum of 12.5 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.



**KENTUCKY MEDICAL GROUP MANAGEMENT
1999 FALL MEETING
HYATT REGENCY – LEXINGTON, KY**

The Physician/Administrator Partnership

Monday, September 27

11:00 AM	Registration – Patterson D
12:00 PM	Luncheon - Kentucky Room
1:15 PM	General Session - Patterson D <i>F. Douglas Scutchfield, MD</i> <i>Leadership Topics TBA</i>
2:30 PM	Break – Late Registration
2:45 PM	General Session – Patterson D <i>F. Douglas Scutchfield, MD</i> <i>Topic TBA</i>
4:00 PM	Late Registration - Patterson D
4:40 PM	Adjourn

Social Event 1999

Tuesday, September 28

7:30 AM	Registration/Continental Breakfast - Patterson D
8:30 AM	General Session – Patterson D <i>Elizabeth Woodcock</i> <i>"Re-Engineering Your Practice"</i>
9:45 AM	Intermission to visit exhibitors
10:15 AM	General Session– Patterson D <i>Rhonda W. Sides, CPA</i> <i>"Enhancing the Value of the Administrator Partner"</i>
11:30 AM	Intermission to visit exhibitors
12:00 PM	Luncheon & Business Meeting - Patterson C
1:30 PM	Breakout Sessions A. <i>Elizabeth Woodcock</i> <i>"Cost Accounting/RVUs" - Patterson D</i> B. <i>Rhonda W. Sides, CPA</i> <i>"Physician Compensation Models" - Patterson C</i> C. <i>Robert Slaton, EdD</i> <i>"Strategic Planning" - Patterson H</i> D. <i>Patrick T. Padgett, Attorney</i> <i>"Fraud and Abuse" - Patterson G</i>
2:00 PM	Intermission to visit exhibitors
2:30 PM	General Session – Patterson D <i>Duane Murray, CEO, Quantum Physician Services</i> <i>"Buy In, Buy Out (Structuring an Arrangement)"</i>
2:45 PM	
4:00 PM	Closing Remarks

**Kentucky Medical
Association's**

Health Fair

Located in the Exhibit Hall

**Tuesday and Wednesday
September 28 and 29**

***Cholesterol Screening
Body Fat Analysis
Blood Pressure Test***

***Stroke Screening
Bone Density
Stress Test***

Paraffin Dip (Arthritis Therapy)

Caricature Artist

Much more!

Services Provided by:

Cardinal Hill Rehabilitation Hospital

Central Baptist Hospital

University of Kentucky Hospital

Veterans Administration Medical Center

Charter Ridge Behavioral Health System

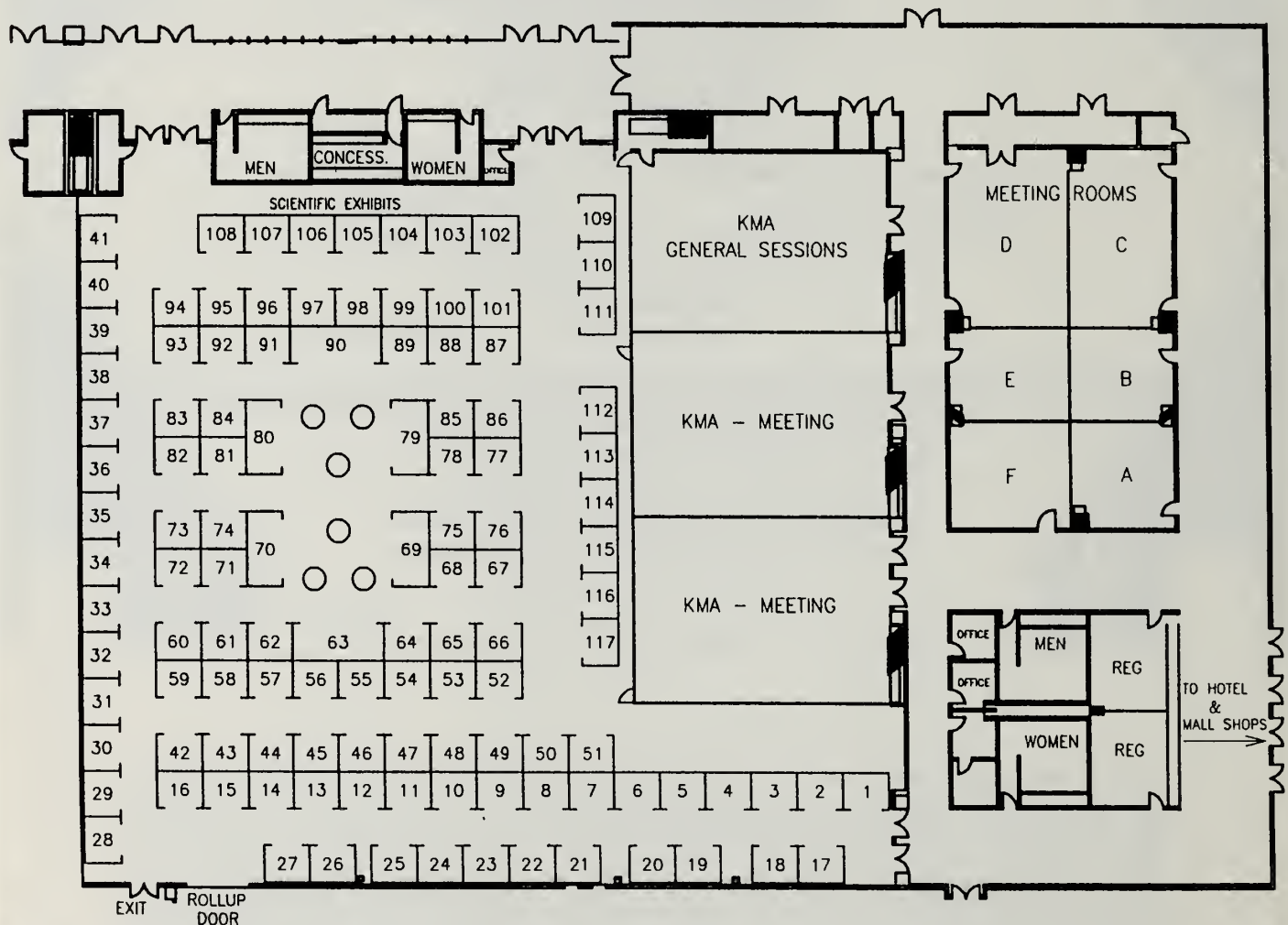
St. Joseph Hospital

AN INVITATION . . .

For a chance to visit with your Annual Meeting Exhibitors, join us each morning (Tuesday and Wednesday) in the Lounge area located in the center of the Exhibit Hall, from 8:15 am - 9:00 am, for free coffee and pastry.

EXHIBIT HALL FLOOR PLAN

LEXINGTON CONVENTION CENTER LEXINGTON, KENTUCKY



All exhibitors with corresponding booth space(s) are listed on this map of the Exhibit Hall. We regret that due to printing and publication deadlines, not all exhibitors are represented in this Exhibit Guide. For more detailed information on the exhibitors, refer to the Technical Exhibits listing beginning on page 387, and please visit them in the Exhibit Hall.

TECHNICAL EXHIBITOR DIRECTORY

Exhibitor	Booth
Abbott Laboratories	101
ADEPT Communications.....	20
AdminaStar Federal – Provider Relations	70
AdminaStar Federal – EDI	70A
Advanced Imaging Concepts	51
Air Force Officer Accessions	42
Alza Pharmaceuticals	65
AmeriPath, Inc.	3
Anthem Blue Cross-Blue Shield	64
Astra Pharmaceuticals	80
Bayer Pharmaceuticals	71
Bluegrass Family Health Inc.	72
Cardinal Hill Healthcare System	52
CHA Health/CHA Provider Network	85
Charles Schwab & Co.	53
Clayton L. Scroggins Associates, Inc.	116
Coverage Options Associates	94
Curative Health Services	74
Dey, L.P.	96
Diagnostic Radiology Systems, Inc.	38
Disability Determination Services	61
Eli Lilly and Company	1
Engravers Paper Company	115
ENVOY Corporation	83
G.D. Searle & Co.	66
Health Care Excel, Inc.	111
Health Care Partners	95
Hoechst Marion Roussel	49
Janssen Pharmaceutica of Johnson & Johnson	75
Kentucky Air National Guard.....	35
Kentucky Medical Insurance Company	63
Kentucky Medical News	100
Kentucky Organ Donor Affiliates.....	113
The Kentucky Spine Institute	68
Key Pharmaceuticals	86
Lexington Diagnostic Center	31
Lincoln Trail Behavioral Health System	59
Mark Kidd Studios	117
Medical Protective Company	69
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AN INVITATION . . .

For a chance to visit with your Annual Meeting Exhibitors, join us each morning (Tuesday and Wednesday) in the Lounge area located in the center of the Exhibit Hall, from 8:15 am - 9:00 am, for free coffee and danish.

Plan to visit the Exhibit Hall during the KMA Annual Meeting. Trained professional representatives will be on hand to discuss with you the details of their products and services in a relaxed atmosphere — with no patients waiting in your outer office and with no telephones ringing.

Located in the Commonwealth Convention Center, the exhibits will condense a volume of information and ideas in such a manner that a vast amount of knowledge can be secured in a short period of time.

The Exhibit Hall is an important part of the Annual Meeting and is the site of registration for all CME courses.

Thirty-minute intermissions have been planned during each general and specialty group session so that every physician may take advantage of this opportunity to benefit their practice and their patients.

Abbott Laboratories #101

200 Abbott Park Rd
Abbott Park, IL 60064-6182
(847) 938-5047

You are invited to visit the Abbott Laboratories exhibit where representatives will be on hand to answer your questions regarding Biacin® (clarithromycin) Tablets and TRICOR™ (fenofibrate capsules), micronized.

AdminaStar Federal #70

9901 Linn Station Rd
Louisville, KY 40223-3824
(502) 425-7776

Medicare Part A Fiscal Intermediary and Medicare Part B Carrier for the Commonwealth of Kentucky.

AdminaStar Federal, EDI Division #70A

9901 Linn Station Rd
Louisville, KY 40223
(502) 423-6756

The Electronic Data Interchange division of AdminaStar Federal promotes electronic commerce to Health Care providers. Some of the transactions supported by AdminaStar Federal include Electronic Media Claims, Electronic Remittance Notice/Advice, Electronic Funds Transfer, Claim Status Inquiry, and Direct Data Entry.

AdminaStar Federal's Web Site, <http://www.astar-federal.com/>, contains information for Medicare Part A, Medicare Part B, and DMERC Region B. Included are EDI Specifications for Medicare and Blue Cross and Blue Shield, Medicare Bulletins, UPIN Directory link, and Local Medical Review Policies.

Advanced Imaging Concepts #51

321 Pearl St
New Albany, IN 47150
(812) 981-2036

Air Force Officer Accessions #42

2515 Perimeter Place Dr
Nashville, TN 37214-3671
(615) 889-0723
Table-top display.

Alza Pharmaceuticals #65

7600 Beech Spring Ct
Louisville, KY 40241
(502) 412-7709

Alza is a 30-year old company specializing in unique drug delivery systems. Our product line includes urology and primary care products including Ditropan XL, Elmiron, Testoderm TTS, and Mycelelex Troche.

AmeriPath, Inc #3

7289 Garden Rd Ste 200
Riviera Beach, FL 33404
(561) 845-1850

Diagnostic laboratories specializing in anatomic pathology. A special emphasis is placed upon catering to the specific needs of the physician.

Anthem Blue Cross and Blue Shield #64

9901 Linn Station Rd
Louisville, KY 40223
(502) 423-2298

Astra Pharmaceuticals #80

501 Corporate Center Dr Ste 300
Franklin, TN 37067
(615) 771-3422

Bayer Pharmaceuticals #71

10301 Riverwalk Lane
Loveland, OH 45140
(513) 697-6275

Bluegrass Family Health, Inc. #72

651 Perimeter Dr Ste 300
Lexington, KY 40517
(606) 269-4475
Managed healthcare plans.

Cardinal Hill Healthcare Systems #52

2050 Versailles Rd
Lexington, KY 40504
(606) 254-5701

Cardinal Hill Healthcare System is comprised of one 100-bed post-acute rehabilitation hospital and five outpatient rehabilitation centers, together offering comprehensive inpatient and outpatient services to both children and adults with mental and physical disabilities. Programs and services offered include treatment for brain injury, spinal cord injury, stroke, amputee, orthopedics, occupational medicine, speech, hearing, physical therapy, occupational therapy, chronic pain management, adult day health, day programs, Multiple Sclerosis, and more. The

system spans the central, eastern and northern parts of Kentucky and is a non-profit, CARF-accredited facility.

CHA Health/CHA Provider Network #85

191 A Lowery Lane
Lexington, KY 40503
(606) 323-1241

Provider-owned HMO insurance company and Integrated Delivery Network serving insured, self-insured, and Medicaid populations. Acting as Kentucky Health Select's administrative partner.

Charles Schwab & Co #53

380 West Main St
Lexington, KY 40506
(606) 425-6500

The Charles Schwab Corporation provides a variety of financial services to individual investors, independent investment managers, retirement plans and institutions. Schwab is one of the largest financial services firms in the United States, serving 6.1 million active investor accounts with over \$564 billion in customer assets. The company provides full-service investing to customers through multiple service channels including the Internet, over 302 branch offices, touch tone and speech recognition telephone, and multilingual technologies.

Clayton L. Scroggins Inc #116

200 Northland Boulevard
Cincinnati, OH 45246
(513) 771-7070

Scroggins Associates provides financial and practice management consulting services exclusively to physicians and dentists. Impartial counsel in a professional, comprehensive and confidential manner on a fee-for-service basis. *Medical Economics* and *Physician's Management* magazines recognize our unique expertise since we serve as editorial consultants.

Coverage Options Associates #94

PO Box 436629
Louisville, KY 40253-6629
(502) 426-6220

Coverage Options Associates is a full-service insurance services firm, providing specialized services to hospitals, physicians, and other health care organizations. Our history of success reflects the pride we take in our southeastern heritage, and our belief that the best client relationships are built upon a foundation of professionalism, integrity, and personal service.

We offer professional liability coverage for physicians, individual and group practice policies, through a competitive, financially sound, A.M. Best A-Rated insurer, Doctor's Insurance Reciprocal.

Curative Health Services #74

150 Motor Parkway
Hauppauge, NY 11788
(800) 966-5656 ext. 2837

The Wound Care Center is a comprehensive outpatient center designed to complement physicians' services. Physicians refer patients to the Wound Care Center for comprehensive wound management but continue to treat the underlying condition and provide for the patient's overall care. Dedicated to management of chronic nonhealing wounds, the Wound Care Center brings together a spectrum of professionals that includes physicians, surgeons and nursing staff.

Dey L.P. #96

2751 Napa Valley Corp Dr
Napa, CA 94558
(707) 224-3299

Dey is a leader in the manufacture and marketing of high quality, sterile unit-dose respiratory solutions with Patient-Focused Packaging™ featuring exclusive Twist-Flex™ vial tops for easy opening and compact cartons to save shelf space. We also market EpiPen® epinephrine auto-injectors, EasiVent™ holding chamber and the Astech® peak flow meter.

Diagnostic Radiology Systems, Inc. #38

301 E Main St Ste 800
Lexington, KY 40507
(606) 231-7644

Diagnostic Radiology Systems, Inc (DRS) is a licensed healthcare provider of mobile Magnetic Resonance Imaging (MRI) and equipment. DRS currently holds several Certificates of Need to provide MR imaging in the State of Kentucky. There are two Siemens 1.0 T MR mobile units and one GE 1.0 T MR unit available to scan at sites in Kentucky.

Diagnostic Radiology Systems, Inc uses shielded magnets and ensures that safe operating practices and procedures are observed. Only qualified personnel operate and service our equipment.

Disability Determination Services #61

PO Box 1000
Frankfort, KY 40602
(502) 564-8050

Disability Determination Services makes decisions of medical eligibility for disability benefits and Medicare for the Social Security Administration. Obtaining detailed, complete medical evidence and information on the disability applicant's ability to function and perform work-related activities is vital to the evaluation of claims for Social Security Disability Insurance and Supplemental Security Income disability benefits.

Neurologists and orthopedists willing to conduct consultative exams are needed. For information, please see our representative.

Eli Lilly and Company #1

4350 Brownsboro Rd Ste 110
Louisville, KY 40207
(502) 893-4518

Engravers Paper Company #115

900 E. Jefferson St
LaGrange, KY 40031

(502) 222-0195

Engravers Paper Company is a manufacturer of traditional fine engraving, high quality thermography and printed stationery. Products include letterheads, envelopes, business cards, announcements, report covers, and presentation folders.

ENVOY Corporation

#83

15 Century Blvd. Ste 600

Nashville, TN 37214

(615) 231-4138

ENVOY Corporation is the nation's largest supplier of electronic data interchange (EDI) services to the healthcare industry, a real-time and batch transaction processing company and the largest electronic claims clearinghouse. We provide easy access to the movement of vital information for hospital, medical, dental and pharmacy transactions through our nationwide electronic network of providers, pharmacies, computer system vendor and payers.

G.D. Searle & Co.

#66

1235 Westlakes Dr Ste 160

Berwyn, PA 19312

(610) 640-4420

Searle is in the business to market innovative value added health care products that help care givers satisfy unmet medical needs. Please visit our booth to learn more.

Health Care Excel, Inc.

#111

2901 Ohio Blvd Ste 112

Terre Haute, IN 47803

(812) 234-1499

Health Care Excel, Incorporated, contracts with the Health Care Financing Administration to serve as the PRO for Indiana and Kentucky. PROs were established to promote quality health care services for Medicare beneficiaries and to determine if services rendered are medically necessary, appropriate and meet professionally recognized standards of care.

Health Care Partners

#95

10500 Bluegrass Parkway

Louisville, KY 40299

(502) 499-9099

Health Care Partners is a team of highly motivated professionals dedicated to providing cost-effective medical equipment, services, and supplies to enhance the patients' quality of life. Our complete programs for both adults and children of all ages have been designed to meet the needs of the patient, family, caregiver, and medical professional.

Hoechst Marion Roussel

#49

140 Windom Lane

Nicholasville, KY 40356

(606) 296-0747

Janssen Pharmaceutica of Johnson & Johnson

#75

1125 Trenton-Harbourton Rd

Titusville, NJ 08560-0200

(800) JANSSEN

Kentucky Medical Insurance Company

#63

& KMA Insurance Agency

303 N Hurstbourne Pkwy

Louisville, KY 40222

(502) 339-5700

Kentucky Medical Insurance Company, a Member of the MI-COA Group, and the KMA Insurance Agency were founded in 1978 by the Kentucky Medical Association with the goal to provide quality insurance to Kentucky physicians. KMIC and KMA Insurance Agency have earned the exclusive endorsement of the KMA since their inception. As the market leader in Kentucky and growing rapidly in neighboring states, KMIC has built a solid reputation as a strong stable company. In partnership with KMIC, the Agency offers a broad array of products and services not only for physicians but for a diversity of families and individuals.

Kentucky Medical News

#100

2121 Richmond Rd Ste 204

Lexington, KY 40502

(606) 266-6019

Kentucky Medical News is a monthly trade publication dedicated to the business of health care throughout the Commonwealth of Kentucky, with an estimated monthly readership of 28,000. The publication currently reaches 100% of the active physicians in Kentucky. As a Kentucky-owned company, KMN is truly "The best health care news in the business."

Kentucky Organ Donor Affiliates

#113

2201 Regency Rd Ste 601

Lexington, Ky 40503

(606) 278-3492

Kentucky Organ Donor Affiliates (KODA) is the not-for-profit organ and tissue procurement organization, serving Kentucky, southern Indiana, and western West Virginia. KODA provides training for hospital staff that provide care to potential donor families. KODA also provides presentations and events to create public awareness regarding organ and tissue donation.

The Kentucky Spine Institute

#68

125 E Maxwell St Ste 202

Lexington, KY 40508

(606) 255-3758

The Kentucky Spine Institute is a provider of comprehensive care of a variety of spinal disorders in children and adults. Disorders treated include degenerative cervical and lumbar conditions, scoliosis, spinal fractures and spinal tumors. Our physicians and staff are dedicated to providing the highest quality of conservative and operative care of spinal disorders. Located in Lexington, Kentucky, the Kentucky Spine Institute is affiliated with Samaritan Hospital.

Key Pharmaceuticals 2661 Idlewood Dr Lexington, KY 40513 (606) 223-0929	#86	The MIIX Group of Companies 111 Monument Circle Ste 3500 Indianapolis, IN 46204 (888) 799-MIIX The MIIX Group is a diversified group of companies that provide financial and insurance products and services, including professional and general liability coverage, to physicians, hospitals, academic health centers, and other health care providers and facilities across the nation. Formed in 1977 by physicians in New Jersey, MIIX has grown to become the leading provider of medical professional liability insurance in New Jersey and is ranked 10 th among medical professional liability insurers in the United States. The MIIX Group currently insures approximately 15,800 physicians and other medical professionals who practice alone, in medical groups, clinics or in other health care organizations. The Company also insures more than 80 hospitals, extended care facilities, health maintenance organizations (HMOs) and other managed care organizations.	#16
Lexington Diagnostic Center 1725 Harrodsburg Rd Ste D Lexington, KY 40504 (606) 278-7226 The Lexington Diagnostic Center offers a complete array of imaging services including Open MRI, High Field MRI, Spiral CT Scans, Fluoroscopy and X-Ray. Our Open MRI is ideal for small children, large patients, and claustrophobics. The 1.5 Tesla, High-Field MRI offers excellent images for neurologic, orthopedic or sports injury cases. Our Spiral CT is significantly faster than traditional CT and provides gapless scanning. Lexington Diagnostic Center is the patient friendly, full-service imaging center.	#31	Milex Products Inc. 3500 Promenade Ct Lexington, KY 40515 (606) 272-0046 Milex is the world's largest manufacturer of pessaries. Included are 24 types indicated for women with uterine prolapse, stress urinary incontinence, cystocele/rectocele and/or vaginal wall prolapse. Milex also manufactures a comprehensive line of disposable cancer detection devices for women including Pipet Curettes, Uterine Explora, Cannula-Curettes, Endometrial Curettes with Tis-U-Traps, Endocervical Curettes and Breast Biopsy Needles for fine needle breast aspiration. Budlong Press the most comprehensive patient education program covering a variety of health topics including prenatal and breast health care and our newest program "Osteoporosis: The Silent Stalker."	#50
Lincoln Trail Behavioral Health System 3909 South Wilson Rd Radcliff, KY 40160 (800) 274-7374 Psychiatric and Chemical Dependency facility treating both adolescent and adults. We offer inpatient, outpatient, intensive outpatient, and day treatment programs.	#59	Natural Speech.MD 432 Lakeshore Dr Lexington, KY 40502 (606) 268-1114 Natural Speech.MD is Kentucky's Premier Partner for Dragon System's Naturally Speaking Medical Suite. The company designs customized, voice activated systems for medical practitioners. Systems include either laptop or desktop computers, stand alone or network based systems and personal training programs for physicians.	#98
Mark Kidd Studios 125 Clay Ave Lexington, KY 40502 (606) 254-1095 Provider of five portrait services for the state and southeast. Range from publicity images direct and digital for website, to family and individual portraits in color, black, and oil.	#117	Norton Healthcare PO Box 35070 Louisville, KY 40232-5070 (502) 629-8653 Norton® Healthcare, a not-for-profit organization, operates Norton Hospital in the Louisville Medical Center, Kosair Children's Hospital, Norton Audubon Hospital, Norton Southwest Hospital, Norton Suburban Hospital and the Norton	#62
The Medical Protective Company 5814 Reed Rd Fort Wayne, IN 46835 (219) 486-0473	#69		
Merck & Co., Inc. 815 Cindy Blair Way Lexington, KY 40503 606-223-7364	#97		
Merck Vaccine Division 770 Sumneytown Pike PO Box 4 West Point, PA 19486-0004	#82		
Merrill Lynch 301 E Main St 12th Floor Lexington, KY 40507 (606) 231-5250	#2		

Healthcare Pavilion in Louisville; Norton Spring View Hospital in Lebanon, KY; five Norton Immediate Care Centers in Louisville and southern Indiana; Carroll County Hospital in Carrollton, KY; and 16 managed community and rural hospitals in Kentucky, Indiana and Illinois. In addition, Norton Healthcare is a partner in University Medical Center, Inc, a not-for-profit organization that manages University of Louisville Hospital and its related facilities. Norton Healthcare also owns Community Medical Associates, Fincastle Medical Group and Southwest Family Medicine, and is affiliated with Floyd Memorial Hospital and Health Services, New Albany, IN; and Regional Medical Center in Madisonville, KY.

Novartis Pharmaceuticals #48

59 Route 10
East Hanover, NJ 07936
(201) 503-7500

Novartis Pharmaceuticals researches and develops, manufactures and markets leading innovative prescription drugs used to treat a number of diseases and conditions, including organ transplantation, cardiovascular diseases, cancer, epilepsy, and arthritis. Novartis Pharmaceuticals in the U.S. is now part of the largest pharmaceutical company in the world.

Olympus America Inc. #67

1805 Crossgate Lane
Louisville, KY 40222
(502) 425-2393

One Alliance Communications #99

465 East High St Ste 200
Lexington, KY 40507-1941
(606) 225-2684

Full service advertising agency specializing in design, public relations, marketing and issue advocacy as it relates to those businesses in the medical community.

Open MRI, LLC #88

7807 Shelbyville Rd Ste 100 Foxwood
Louisville, KY 40222
(502) 429-6500

A new state-of-the-art GE Scanner. We specialize in claustrophobic and anxious patients. Our scanner accommodates patients up to 425 lbs. Located in Louisville directly across from Oxmoor Center. Peter Rothschild, MD, has over 10 years experience in reading Open MRI scans.

Ortho McNeil Pharmaceutical #79

1000 Route 202
Raritan, NJ 08869-0602
(215) 628-5000

The Pain Treatment Center #93

280 Pasadena Dr
Lexington, KY 40503
(606) 278-1316

This display will utilize a 48" x 36" poster board, which the following information pertaining to The Pain Treatment Center, a fully licensed Ambulatory Surgery Center: 1) Definition of chronic pain; 2) Treatment approach and goals; 3) Initial consultation studies; 4) Variety of diagnostic services; 5) Controlling the cost. Videos of the various treatment modalities will be available for viewing. Newly revised brochures providing current information regarding the Pain Treatment Center will be supplied.

Pharmacia & Upjohn, Inc #110

3552 Creekwood Dr #5
Lexington, KY 40502
(606) 268-2007

Announcing new treatments in overactive bladder, Type II Diabetes, and intermittent claudication.

Pikeville Methodist Hospital #19

911 South Bypass Rd
Pikeville, KY 41501
(606) 437-3985

Professionals' Purchasing Group, Inc #60

250 Whittington Pkwy.
Louisville, KY 40222
(502) 423-7201

Professionals' Purchasing Group, Inc (PPG) is a provider of group purchasing, and management support services, as well as insurance related services to over 600 medical practices in the tri-state region of Kentucky, Ohio, and Indiana.

PPG's goals are simple—to assist their clients in reducing the costs associated with operating a healthcare business, and to enhance the financial performance of their clients' practices.

ProNational Insurance Company #78

2600 Professionals Dr Box 150
Okemos, MI 48805-0150
517-349-6500

Dedicated to providing professionals and entities with the best professional liability insurance, service and related products since 1975, ProNational Insurance Company proudly protects thousands of policyholders throughout the United States. Rated A- (Excellent) by A. M. Best, we are known for our superior risk management services and strong defense. Our local network of knowledgeable, service-oriented independent agents stands ready to help deliver ProNational's strength.

Quantum Physician Services, Inc #109

270 Southland Dr Bldg A
Lexington, KY 40503
(606) 278-1144

Quantum Physician Services, Inc is a full service physician management and consulting company specializing in computer solutions. Whether your need is practice assessment, a cost accounting project, or a new computerized billing system, Quantum has the expertise. "RELY ON US. . .

... WE KNOW!" Talk with us about The Medical Manager system, the most widely installed physician practice management software in the US, and BridgeIt, reporting software that integrates The Medical Manager and Microsoft Office Tools.

Roche Pharmaceuticals #112
340 Kingsland St
Nutley, NJ 07110-1199
(800) 285-4484

Roerig (Division of Pfizer) #89
520 Navaho Rd
Shelbyville, KY 40065
(502) 647-3774

Ross Products Division, Abbot Laboratories #76
76 Pinebrooke Dr
Westerville, OH 43082
(800) 986-77298

SharpCare LLC # 4
3991 Dutchmans Lane Ste 414
Louisville, KY 40207
(502) 895-4440
SharpCare LLC is a surgeon supervised wound program dedicated to meet the needs of long term care residents. Physician extenders (nurse practitioners and physician assistants) travel to long term care facilities to provide care alleviating the need for the resident to leave the facility unless more extensive treatment is needed ie: surgical debridement. Physician extenders take pictures of the wounds with a digital camera and have the ability to download the pictures to the physician for review. The physician extenders treat the wound at the bedside and write orders for continuous treatment of the wound. The extenders visit the resident weekly until the wound is healed and then prn.

Sleep Medicine Specialist #92
1169 Eastern Pkwy Ste 3357
Louisville, KY 40217
(502) 454-0755
At Sleep Medicine Specialist it is our goal to restore your quality of life by helping you achieve restful, restorative sleep. The physicians and technologists have years of practical experience and use state of the art equipment. Our facilities are designed to provide the greatest possible comfort and privacy and we are certified by the American Sleep Disorders Association.

STATCARE #5
2807 Taylorsville Rd.
Louisville, KY 40205
(502) 479-9100

State Volunteer Mutual Insurance Company #90
PO Box 1065
Brentwood, TN 37024-1065

(615) 377-1999
SVMIC is a physician owned and operated company providing professional liability insurance to over 10,000 physicians in Alabama, Arkansas, Georgia, Kentucky, Mississippi, Tennessee, and Virginia since 1976. Experienced staff attorneys are available to answer policyholders' inquiries as well as manage claims. SVMIC provides educational resources such as Risk Management Seminars and the Medical Practice Services Department, which can assist in the business of running a practice, or help with issues such as compliance and Y2K.

TAP Pharmaceuticals #87
345 Albany Rd
Lexington, KY 40503
(606) 276-4995
Makers of Prevasid.

Team Health #73
1900 Winston Rd. Ste 300
Knoxville, TN 37919
(423) 693-1000
Team Health is the nation's leading provider of hospital-based clinical services. We contract with hospitals to provide outsourced services in the areas of emergency medicine, radiology, anesthesia and hospitalist programs. Operating through regional offices strategically located throughout the country, we provide state-of-the-art services on a local level.

Physicians who join Team Health enjoy attractive practice locations in twenty-five states, competitive compensation and benefits and affiliation with other physician leaders within the organization. Continuing education, clinical practice guidelines, information systems and tools, and opportunity for advancement are provided for the physicians within the group.

University of Kentucky Hospital #114
935 South Limestone
Lexington, KY 40503-9828
(606) 323-4843

The physicians practicing at the UK Chandler Medical Center are committed to meeting the consultation and referral needs of physicians throughout the Commonwealth. Comprehensive services include cancer and cardiac specialties, neurosciences, obstetrics and gynecology, and pediatrics. The 473-bed hospital offers Level I trauma care, organ transplantation, neonatal intensive care, a children's hospital, magnetic resonance imaging and multidisciplinary programs. Visit our booth to learn more about our physician access service including the UK-MDs physician-to-physician 800 number.

Wallace Laboratories #91
PO Box 1001
Cranbury, NJ 08512
(609) 655-6574

We invite you to visit the Wallace Laboratories booth. Representatives will be available to provide information and/or answer questions regarding our ethical products: Tussi-12™

Suspension, Rynatan® Tablets, Rynatan-S®, Soma®, and Astelin® Nasal Spray.

Whitehall-Robins Healthcare

#77

5718 Beechgrove Lane
Cincinnati, OH 45233
(513) 922-6063

ZirMed.com

#33

4323 Poplar Level Rd
Louisville, KY 40213
(502) 473-7709

ZirMed.com's new approach to claims filing is revolutionizing the healthcare industry. No longer do physicians have to buy, install, and update expensive claims software and systems. Subscribers can now use our efficient, error-reducing system simply by logging onto a Web browser—all that's needed is a computer and Internet access. ZirMed.com's programs (patent pending) are Y2K compliant, HIPAA ready, secure, and reliable. More information and demonstrations are available at www.zirmed.com.

We regret that printing deadlines prevented alphabetical listing of the following exhibitors:

ADEPT Communications

#20

1170 E. Broadway, Ste 202
Louisville, KY 40204
(502) 584-1807

Kentucky Air National Guard

#35

1101 Grade Lane
Louisville, KY 40213-2616
(502) 364-9423

Rexall Showcase International

#84

4898 Faulkirk Lane
Lexington, KY 40515
(606) 272-8419

SmithKline Beecham Pharmaceuticals

#36

4445 Lake Forest Dr, Ste 490
Cincinnati, OH 45242
(513) 733-5354

St. Joseph Hospital

#81

One Saint Joseph Dr
Lexington, KY 40504
(606) 278-3436

Stinger Industries LLC

#21


818 Old Salem Pike
Murfreesboro, TN 37129
(615) 896-1652

Stinger Industries manufactures mobile computer workstations for virtually all types of computer hardware and mobile applications. THE LEVITATOR™ line includes models for tradi-

tional PC's with glass monitors, flat panel monitors, and notebook computers. High mobility and battery options make THE LEVITATOR™ the missing link in your wireless network. Plentiful work surfaces, optional medicine cabinets, ad bracketing for monitoring equipment turn THE LEVITATOR™ in to a true point-of-care workstation. The CompuCab™ offers premium protection of equipment and information.

AN INVITATION . . .

For a chance to visit with your Annual Meeting Exhibitors, join us each morning (Tuesday and Wednesday) in the Lounge area located in the center of the Exhibit Hall, from 8:15 am - 9:00 am, for free coffee and danish.



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Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates: \$40 per insertion (\$20 for KMA members) for the first 30 words; 50¢ for each additional word.

Send advance payment with order to: The Journal of KMA, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222.

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Manuscripts — Articles will be accepted for consideration with the understanding that they are original and are contributed solely to this *Journal*. The transmittal letter should designate one author as correspondent and include the author's address and telephone number. Receipt of manuscripts will be acknowledged and unused manuscripts returned. All material is reviewed by the Board of Editors and publication of any article is not to be deemed an endorsement of the views expressed therein.

Preparation — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.

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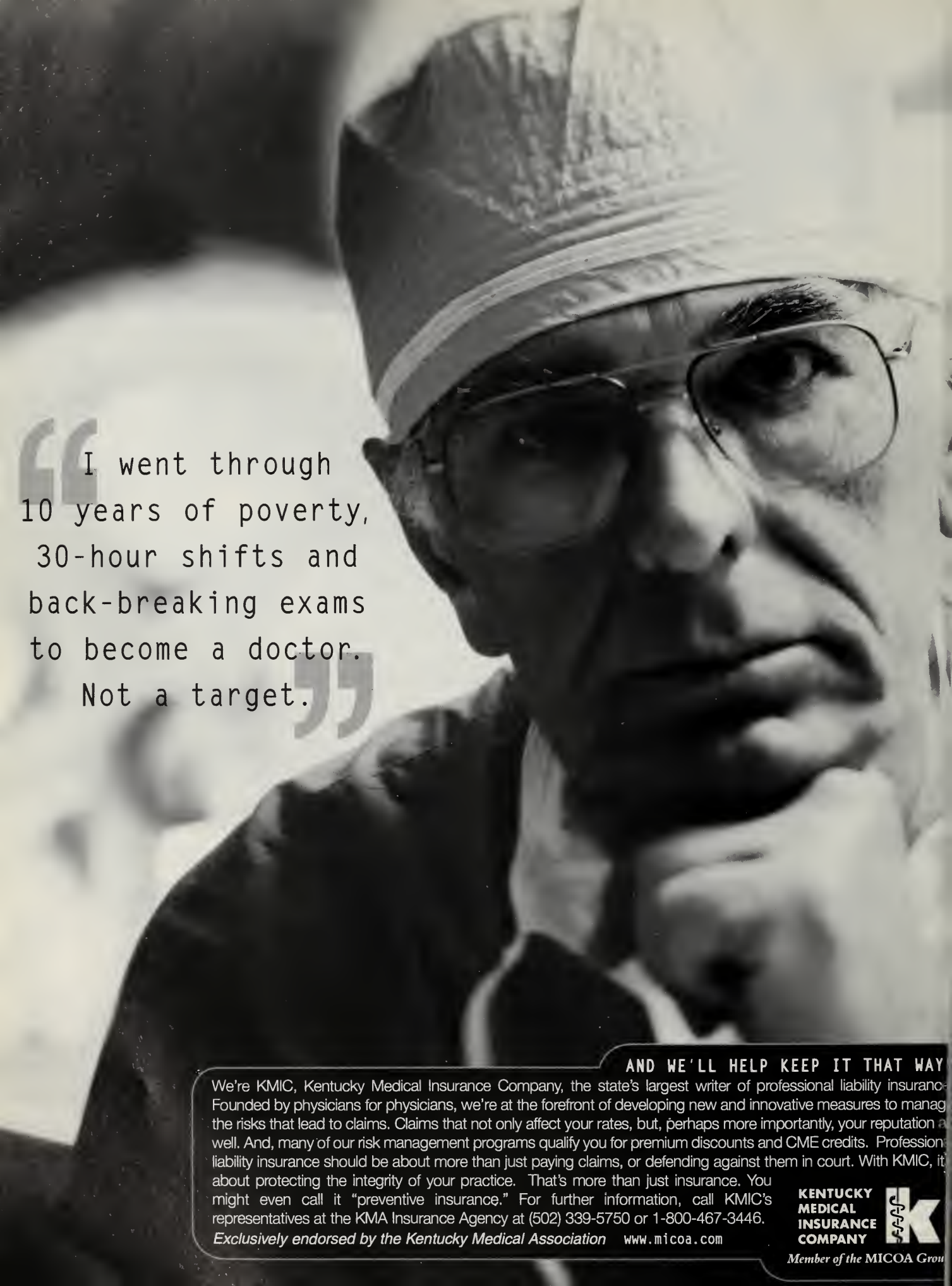
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A UofL surgeon discusses different breast reconstruction options for women following mastectomy.

Artwork by Alexander G. Digenis, MD, of Louisville, KY.

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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Periodical postage paid at Louisville, KY and additional offices. Yearly subscription rates: \$35 domestic; \$45 foreign. Single issues \$4 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222. Telephone 502/426-6200 Fax 502/426-6877 Email member@kyma.org

Listed in *Index Medicus*. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

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Printed by the Ovid Bell Press, Inc, Fulton, Missouri 65251.

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TO WHOM MUCH IS GIVEN—MUCH IS EXPECTED



At the beginning of the Association year, I pointed out that no organization, group, or profession can match Kentucky physicians and their spouses when it comes to caring for the poor, addressing tobacco, drug, and alcohol abuse, and working to prevent and treat domestic violence. You and your spouses have been leaders in promoting educational reform, funding medical education, and urging Kentucky's political leadership to address health and safety proposals, especially those that threaten our young people.

On the local level, you have operated free clinics for the indigent, uninsured, and homeless. It is fairly common for most medical practices to treat 5-10% of patients, unable to pay for medical care. Statewide, 2000 physicians donate their time and office resources by participating in Kentucky Physician Care. Without fanfare, we simply proceed quietly about our business and treat our patients—all of our patients—regardless of ability to pay.

We are engaged in our communities and in political life. You have participated in thousands of local projects and fund raisers that benefit your community. We serve on City Councils, Boards of Education, and Boards of Health. Many of us belong to local civic clubs and are major participants in fund raising exercises benefiting our community, state, and nation. Historically, physicians have been dismissed within political circles as "aloof" and "being above politics." That myth has been exposed. According to the *Courier-Journal*, "Physicians have emerged as big players in politics, and make the largest contributions of any occupational group." Most of us are far more involved in the

political life than even the politicos are aware.

We began the year criticizing HMOs and managed care and will end on a similar note. In August, KMA testified before an Interim Committee of the General Assembly. The Committee was seeking to determine the cost-drivers of medical care. My remarks were brief and pointed. Physicians are asking the same exact question. Provider fees have been reduced 30-50%, and on a daily and hourly basis, patients are being denied-delayed-or ignored in their effort to obtain medical care. Despite HMO and managed care press releases, premium increases for groups are routinely jumping 25-35% annually. Physicians and patients are looking for answers. Only Congress and the General Assembly can probe behind the wall of "proprietary privileged information" thrown up by HMOs and managed care to avoid the truth.

Despite the doom and gloom, I am optimistic that we will overcome the hurdles imposed upon us. Patients and physicians have never been more united. Sooner or later this nation will rise up against a system that rakes 20-40% off the top, and in the same breath denies necessary care. These folks tipped their hands at the outset. They attempted to cram "drive-through mastectomies and deliveries" down the public's throat and even denied women and children direct access to pediatricians and OB-GYNs. That effort created a national furor among women, child advocates, and physicians. If they continue on this path (and they surely will), the public's response to managed care may well be that "old bugaboo," the single

payor system. Many patients and physicians already prefer and find Medicare far more efficient to work with than most managed care outfits. HMOs and managed care can't have it both ways. The electorate will not tolerate HMOs and managed care cancelling or refusing to insure poor, elderly, and frail, while opposing government programs for the very ones they refuse to insure.

In closing, I want to express my sincere thanks for your support and assistance. Special thanks to the House of Delegates for providing the opportunity to serve as President, and to a Board of Trustees and staff that always rallied to the cause—often at a moment's notice. Special mention should be made of the Kentucky Medical Association Alliance officers and members for their efforts to improve the lives of Kentuckians. Throughout the year, I have consistently supported united action among county, state, national, and specialty groups. Of all these groups, AMA is most imperiled. Further

erosion of AMA is not in the best interests of patients and this profession. Without a single national voice we become easy pickings. Just ask our neighbors to the North.

We are a proud and a noble profession. Physicians will continue, as we always have, to take care of sick patients, despite their ability to pay. Patients are our friends and allies. The special covenant that binds us to each other will eventually serve to prevail against those who abuse the public trust for profits—whoever they are.

Sonya and I have enjoyed the special camaraderie and friendship while serving as your President. We are "not quite" ready for retirement and look forward to serving patients and the profession in other capacities. Thanks again for a great year.

Donald R. Stephens, MD
KMA President

MONITORING Medicine

NEWS FOR KENTUCKY PHYSICIANS

Many physicians have requested information on "all products" contract clauses and how such clauses might affect them. To educate physicians on this issue the AMA and KMA developed the following information:

"All Products" Clauses

- What is an "all products clause"? An all products clause is a clause in a health plan physician contract that requires, as a condition of participating in *any* of the health plan products, that the physician participate in *all* of the health plan products, *present or future*.
- Are "all products clauses" new? They appear to be the latest in what is a trend among large, dominant health plans to draft more and more onerous contracts that they present to physicians on a "take-it-or-leave-it" basis. In the past 18 months, the all-products clause has appeared in a number of health plan contracts across the country.
- How many health plans use "all products clauses"? Such clauses are becoming increasingly common, particularly among market leaders. For example, Aetna U.S. Healthcare, Cigna, and some Blues plans around the country are requiring physicians agree to an "all products clause."
- Can physicians opt-out of the "all products clauses"? Aetna U.S. Healthcare has publicly stated that the provision is non-negotiable.
- Why are "all products" clauses so objectionable? There are a number of important reasons why these clauses—particularly when they are non-negotiable—may be troubling to physicians. Health plan products differ substantially in operation. For example, a physician may feel comfortable participating in a PPO product, but may have very valid reasons for not wanting to participate in an HMO product, which is a dramatically different product that requires physicians to assume insurance risk. A risk contract may not be a viable business option for smaller practices with smaller patient bases because of the practice size, patient risk or other valid actuarial and business concerns. A large group may have valid concerns that the plan does not have computer systems to provide the data needed to manage the insurance risk. In addition, many of these clauses require physicians to accept future contracts with unknown and unpredictable business risk.

MONITORING Medicine

- How do health plans try and justify these clauses? Health plans argue that they want a uniform network across product lines and that the all-products clause is intended to protect continuity of care. However, a patient who chooses to see his or her physician through a health plan PPO will be unable to if that physician does not wish to participate in the HMO—even when that patient has not chosen an HMO.
- How are patients affected by these clauses? The “all products clause” can disrupt and/or sever existing physician-patient relationships. This has been seen most vividly in Dallas, Texas, where Aetna/U.S. Healthcare enforced its “all products” clause and terminated a large IPA from its PPO network when that physician group terminated its contract with the HMO product. In Kentucky and South Carolina, the “all products clause” has been a deal-breaker in negotiations between Aetna and large physician groups, and patient dislocations have resulted.
- What are the long-term implications of the “all products” clause? As the health plan market continues to consolidate and plans obtain significant market share, the non-negotiable “all products” clause will operate to further limit patient choice by facilitating a conscious push of patients into HMOs.

EXAMPLE OF AN ALL PRODUCTS CLAUSE

Plan Participation. Company has and retains the right to designate Provider as a Participating Provider or non-participating provider in any specific Plan. Company reserves the right to introduce new Plans during the course of the Agreement. Provider agrees that Provider will provide Covered Services to Members of such Plans under applicable compensation arrangements determined by Company. Provider shall accept compensation in accordance with this Agreement for the provision of any Covered Service to Members under a Plan, regardless of whether Provider is a Participating Provider in such a Plan. Company has or intends to seek a contract to serve Medicare and/or Medicaid beneficiaries. Such beneficiaries shall be considered as Members. Provider shall be bound by all requirements applicable to such contract and all rules and regulations of the Medicare and Medicaid programs.

KMA News Review

Below are synopses of news items that have appeared recently in various publications regarding issues of interest to Kentucky physicians.

- Three years after New York State enacted managed care legislation, a survey of New York City physicians found that many managed care abuses continue, and in many cases have grown worse. Physicians indicated that in the last 2 years, many managed care companies have required prior authorization for a range of minor procedures and tests. Many of those interviewed for the survey indicated that managed care companies create such a complicated gauntlet to obtaining permission for services that many medical providers are discouraged from trying. [*New York Times*]
- Blue Cross Blue Shield of Florida announced it is switching to fee-for-service reimbursement for primary care physicians in Jacksonville. The move is designed to improve access to physicians, discourage physicians from taking on too many patients, and cut down on unnecessary referrals to specialists. [*AMNews*]
- A study conducted by the Harvard Medical School and the Public Citizen Health Research Group found that not-for-profit HMOs are more likely than for-profit HMOs to make sure patients receive preventive treatment. The study concluded that for-profit HMOs' moneymaking mission compromises patient care. [*CNN Interactive*]
- Despite the fact HMO cost-cutting approaches were supposed to have cut down on emergency room visits, many managed care companies have left their members no other place to go after-hours and on weekends. While patients covered by indemnity plans may have more options regarding which physicians they can see, HMO patients are restricted, which leads many of them to the emergency room. Managed care plans acknowledge the problem, but say it would cost too much to provide other after-hours options to their members. [*Wall Street Journal*]
- Amid growing frustration of hospitals and physicians, many organizations are considering legislative and legal action to force managed care companies to pay claims in a timely manner. While the American Hospital Association is trying to educate its members on contract language to help with the problem, the California Medical Association is considering a class action lawsuit against managed care companies. [*Bureau of National Affairs, Health Law Reporter*]
- Two Columbia/HCA executives were found guilty of Medicare fraud by a jury in Florida. The case centered around Medicare reimbursements to a hospital in Port Charlotte, Florida, and resulted from a "whistleblower" lawsuit filed by a former Columbia employee. Prosecutors say the convictions show that juries do understand the Medicare rules well enough to convict someone of fraud. [*Bureau of National Affairs, Health Law Reporter*]
- A report issued by the National Institute for Health Care Management found that four categories of drugs accounted for 31% of the total \$42.7 billion rise in drug costs between 1993 and 1998. The four categories include oral antihistamines, antidepressants, cholesterol-reducing drugs, and anti-ulcer drugs. Higher prices for drugs accounted for two-thirds of the increased costs, while rising use accounted for one-third. [*Wall Street Journal*]
- While many experts predict a physician "glut," Richard A. Cooper, MD, Director of the Health Policy Institute, disagrees. Factoring in such variables as overall population and aging physicians, Dr Cooper predicts an "abundance" of physicians, but not a glut. He believes plans to cut the number of training positions should be abandoned because there will be a steep fall in the number of physicians by 2010. [*AMNews*]

BREAST RECONSTRUCTION AFTER MASTECTOMY

Alexander G. Digenis, MD

Breast cancer is the most common cancer in women in the United States, with 1 out of 9 women developing breast cancer in their lifetime and approximately 180,000 women diagnosed with breast cancer per year.¹ Although breast-conserving surgery combined with postoperative radiation therapy is a therapeutic option for early stages of breast cancer, often the location, size of the woman's breast, or the woman's choice necessitates mastectomy. Recent advances in the surgical techniques of both oncologic resection as well as reconstruction offer improved options for breast restoration using prosthetic implants and autologous tissue transfer. These advances have allowed plastic surgeons to achieve a level of symmetry with near "normal-appearing" breasts, in contrast to the amorphous breast mounds that were typical of earlier procedures. This article reviews the timing, selection criteria, the most common reconstructive options, and addresses some specific concerns raised by referring colleagues and patients.

ADVANTAGES OF IMMEDIATE BREAST RECONSTRUCTION

Breast reconstruction can be performed as an "immediate" (at the same time of mastectomy) or "delayed" (after recovery from mastectomy)



procedure. Several studies have indicated that there may be both aesthetic and psychological benefits to immediate reconstruction, when possible.²⁻⁵ The greater ease of dissection through non-scarred tissue allows increased control in molding the breast envelope and recreating the inframammary crease. Furthermore, authors such as Mathes et al⁶ argue that there are no significant differences in overall complication rates between immediate or delayed reconstruction, regardless of the reconstructive technique. However, immediate reconstruction has the advantage of exposing the patient to only one major procedure with improved aesthetic results and no increase in complications.

Immediate breast reconstruction represents a significant advance in the treatment of breast cancer. It addresses the psychosocial morbidity associated with the deformity caused by mastectomy. These abnormalities include depression, loss of sexual interest, a negative body image, a heightened fear of recurrence, and other mood disturbances.²⁻⁵ In patients undergoing immediate breast reconstruction, these psychological stresses appear to be lessened and allow the patient to recover and deal more effectively with their disease.³⁻⁵ Unfortunately, women who are considering immediate reconstruction often may be overwhelmed by a bewildering array of options at a time when they are already taxed with the realization that they have breast cancer. It is a challenge, therefore, for the plastic surgeon to guide patients through the process of exploring their options for reconstruction.

CANDIDATES FOR RECONSTRUCTION

All women who undergo mastectomy or chest-wall resections are candidates for breast reconstruction. Nipple involvement, large central lesions, multifocal disease, small breast size, multiple biopsy incisions, and the patient's choice often precludes breast conservation (lumpectomy, axillary dissection, and radiation). Patients with poor aesthetic results from lumpectomy or complications of other reconstructive methods are also potential candidates. Careful preoperative evaluation and assessment must be performed to select the appropriate reconstruction

for each patient. All patients require an in-depth and detailed initial consultation with both their plastic surgeon and general surgeon to determine the best options based on pathology, status of the contralateral breast, and technical reconstructive considerations.

SELECTION OF TECHNIQUE

There are essentially three techniques for breast reconstruction that are most commonly used after mastectomy: (1) prosthetic implant placement with or without tissue expansion, (2) autologous tissue transfer, or (3) a combination of both autologous tissue and implant. The four major factors to determine which technique to use include:

- 1) The patient's overall body habitus and health including planned chemotherapy and radiotherapy
- 2) The site and extent of mastectomy
- 3) The size and shape of the contralateral breast, and
- 4) The preference of the patient

Body Habitus and Health

The health of the patient may influence the type of reconstruction. An older patient or those with comorbid conditions are probably best suited for simpler procedures, such as tissue expansion and implant placement. Autologous tissue breast reconstructions, in contrast, are generally longer and necessitate equipment and staff with requisite training to perform these procedures safely.

Many surgeons consider smoking, diabetes, or obesity as relative contraindications to autologous tissue reconstruction.^{6,7} Higher rates of flap loss and wound complications occur due to the compromised microcirculation in the tissues associated with these conditions. Nevertheless, preoperative measures may be taken in

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these patients to improve blood supply to the flap. First and foremost, the patient is encouraged to stop smoking. Another method to improve perfusion to the skin flap is through a technique known as a "vascular delay." This is accomplished by ligating collateral circulation to the flap in a staged procedure 1 to 3 weeks prior to the reconstruction. Flap survival is increased and wound healing problems are minimized.⁸ Dowden and Yetman,⁹ for example, found that "vascular delay" decreased wound complications in patients who were obese, who had prior chest-wall irradiation, and who smoked. In addition, previous surgical incisions near potential donor sites may also divide the vascular supply (pedicle) to potential flaps, thus preventing or limiting tissue transfer.

Chemotherapy and preoperative chest-wall irradiation also influences the choice and timing of breast reconstruction.¹⁰ Chemotherapeutic agents such as adriamycin or preoperative irradiation may retard wound healing. A period of 6 to 8 weeks should pass to allow tissues and blood counts to recover.

In patients restored with implants, radiotherapy significantly worsens the aesthetic outcome due to the association of increased capsular contraction.¹¹ Unfortunately, the identification of the patients who need postoperative irradiation is usually not determined until after surgical staging of their breast cancer. If adjuvant radiotherapy is necessary after implant-based reconstruction, expansion is performed in the immediate postoperative period prior to starting irradiation. This improves the aesthetic result, since tissue expansion is more difficult and painful in scarred irradiated tissue. If preoperative irradiation is necessary, implant placement is often delayed or autologous tissue reconstruction is employed.

Adjuvant irradiation, although increasing the risks of wound complications, is better tolerated with autologous reconstructive techniques. The patient must be made aware, however, that radiation may compromise the viability of skin flaps, increase the incidence of fat necrosis, scarring, and telangiectasias of the skin.^{10,11} Despite the adverse effects of these

adjunctive treatments, immediate reconstruction with autologous tissue still produces the best aesthetic results.

Site and Type of Mastectomy

The site and type of mastectomy performed plays an important role in determining the selection of breast reconstruction. A modified radical mastectomy will leave more ample tissue than a radical mastectomy. In addition, skin involvement may also leave large tissue defects, complicating closure and coverage of underlying tissues. The quality of the skin flaps, previous breast scars, as well as the condition of the pectoralis muscle must be taken into account preoperatively as well as intraoperatively.

One of the major advances in immediate breast reconstruction has been the changing attitudes of surgeons and the evolution of the mastectomy technique. Among these changes is the growing acceptance of the skin-sparing mastectomy. This technique removes the nipple-areola complex, previous biopsy incisions, and the underlying breast tissue while preserving the skin envelope and inframammary fold (IMF). Kroll et al¹² from M.D. Anderson Cancer Center (Houston, TX) reported on 100 patients with no evidence of increased recurrence or survival when using this method. Additional reports have also verified the oncologic safety in performing this procedure, even with invasive breast cancer.¹³ Preservation of the skin envelope and the IMF enhances the ability of the reconstructive surgeon to recreate a more natural-appearing breast. A more accurate estimate of volume and shape can be made by preserving the outer shell of the breast. Furthermore, this "skin brassiere" more effectively camouflages the underlying autologous flap, except for the skin defect of the missing nipple-areola complex or biopsy site.

Shape and Size of Contralateral Breast

The shape and size of the contralateral breast is paramount in establishing symmetry and deciding which type of reconstruction is best suited for the patient. Often, reduction or

mastopexy of the contralateral breast must be performed to better match the planned reconstruction, particularly in the mature ptotic breast. If the patient is thin, a contralateral augmentation for symmetry may also be necessary. Such contralateral surgery was often withheld in the past due to limited insurance coverage. Fortunately, the United States Congress recently recognized the importance of reconstructive surgery after mastectomy and passed the "Women's Health and Cancer Rights Act of 1998"¹⁴ stipulating that:

1. The attending physician and patient are to be consulted in determining the appropriate type of surgery.
2. Coverage must include all stages of reconstruction of the diseased breast, procedures to restore and achieve symmetry on the opposite breast, and the cost of prostheses and complications of mastectomy, including lymphedema.

SURGICAL TECHNIQUES

Implant Reconstruction

In the early 1970s, implant use was limited to immediate placement after mastectomy. Unfortunately, this technique rarely produced a natural-appearing breast. This was because of the limited amount of tissue available to create an adequate breast envelope secondary to excessive skin resection. Thin "breast" skin flaps after mastectomy could be jeopardized by undue tension after immediate implant placement. In the early 1980s, the introduction of tissue expansion revolutionized implant reconstruction after mastectomy. This technique is performed by placing a deflated expander underneath the skin and muscle of the mastectomy site. The expander is generally placed in a subpectoral pocket medially, anterior serratus laterally, and rectus abdominis fascia inferiorly, allowing for complete muscular coverage of the implant (Figure 1). This not only provides for additional tissue thickness to camouflage the underlying implant, but it also protects the implant from exposure if the overlying skin flaps suffer necrosis.

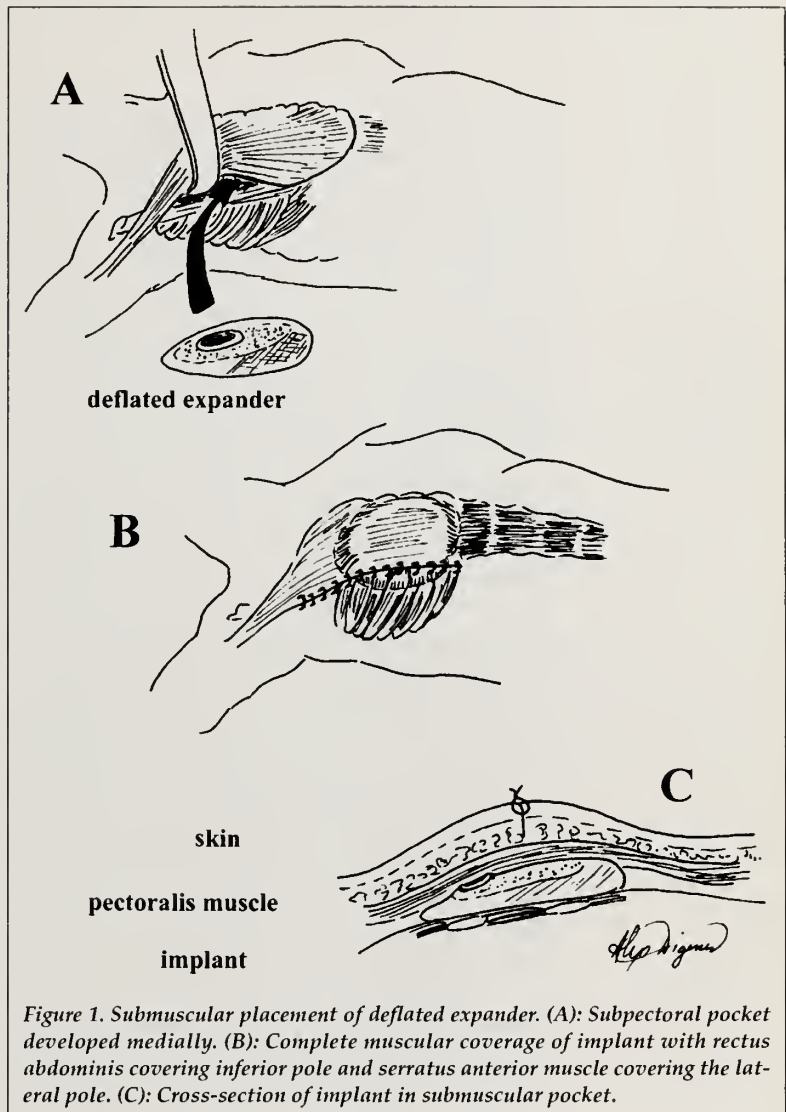


Figure 1. Submuscular placement of deflated expander. (A): Subpectoral pocket developed medially. (B): Complete muscular coverage of implant with rectus abdominis covering inferior pole and serratus anterior muscle covering the lateral pole. (C): Cross-section of implant in submuscular pocket.

Postoperative tissue expansion creates an increased chest-wall skin envelope to accommodate a larger and more naturally contoured implant at a second operation. This process of expansion stimulates overlying tissue to grow (increased mitosis) as well as stretch. Normally, after healing of the mastectomy wounds, expansion begins in the clinic or office setting using saline solution injected into a specialized integrated port through the overlying skin. The site of injection depends on the design of the expander. The most common type uses an integrated port located on the superior pole surface. Other designs use remote ports that can be buried in the axilla. The integrated port design

is localized with a magnetic port finder. Injection of saline is usually well tolerated by the patient after infiltration of a local anesthetic in the overlying skin.

If postoperative healing occurs without a problem, expansion normally begins within 10 to 14 days. The expander and final implant must be selected by careful preoperative measurements, accounting for chest-wall width (base width), vertical height of the chest, as well as desired projection. Total implant volumes vary, depending on the anatomy of the patient, but generally, these range between 400 and 800 ml. Each session of expansion ranges between 50 and 100 ml of fluid, depending on the tolerance of the patient. The end point of each expansion session is accompanied by a mild sensation of pressure in the expanding breast envelope. The expansion process averages between 4 to 8 weeks. When the maximal fill volume is achieved, the patient's tissue is allowed to mature and soften over an additional 4 to 6 months. This is believed to decrease the incidence of contracture around the permanent implant. At this time, a second outpatient operation is performed to remove the thick-walled expander and replace it with a more naturally contoured permanent implant through the previous mastectomy scar. This also allows for adjustment of the implant position and surgical creation of an IMF. In contrast to older round implants, current reconstructive implants are available in a variety of shapes more closely mimicking the natural anatomic shape of the breast. These prostheses limit the upper pole fullness, while lowering the point of maximal projection. Custom-made implants may also be fabricated. New textured surfaces are believed to prevent migration of the implant as well as decrease the incidence of distortion and firmness due to capsular contracture.^{15,16}

Advantages of implants. Advances in surgical techniques and improvements in implant design have allowed for applications to a wider range of body shapes that were previously difficult to reconstruct with implant placement alone. The major advantage of implant placement after expansion is the minimal additional

surgery required at the time of mastectomy and the lack of donor site morbidity associated with tissue transfer. The recovery time of the patient usually follows the same time course expected after mastectomy alone.

Disadvantages of implants. Breast reconstruction implants, although more accurate anatomically, are best suited for small- to moderate-sized breasts, with minimal ptosis. They generally produce unacceptable cosmetic results in patients with large breasts and advanced ptosis, unless contralateral breast reduction or shaping is performed. In contrast, when bilateral mastectomy is required, implants provide excellent symmetry, since expansion of both sides can be simultaneously controlled. Implants have been criticized for poor inframammary definition, particularly when trying to recreate a large ptotic breast. In addition, implants placed for breast reconstruction have a higher rate of capsular contraction, particularly when chest-wall irradiation is used as an adjunctive treatment.^{12,13}

The major disadvantage of tissue expansion and implant placement, therefore, relates to patient selection based on contralateral breast shape and size. In addition, multiple postoperative office visits for serial inflation may pose logistic problems for patients (ie, long travel distances or work). A second procedure to insert a permanent prosthesis is also generally required, although newer hybrid permanent expander implants may prevent the need for secondary exchange. Placement of prosthetic implants may be occasionally complicated by infections (1.9% to 4%), extrusion (1%), and problematic capsular contractures (8% to 21%).^{16,17} The incidence of capsular contraction has decreased in several recent studies, which is thought to be due to submuscular placement of the implant, a new surfaced textured design, and the use of saline-filled implants rather than silicone gel.¹⁵⁻¹⁷ Although silicone implants have been identified in having a higher rate of capsular contracture than saline, the viscous nature of silicone produces a more natural feel and look to the reconstructed breast.^{16,18} Despite the recent moratorium on use of silicone implants in aesthetic augmentation, they still may be used for

breast reconstruction under an FDA-approved protocol. Several recent reviews have refuted previous claims of autoimmune or inflammatory tissue disorders and their association with silicone implants.^{18,19} It is anticipated that silicone implants for breast reconstruction will be available off protocol this year. Several new designs incorporating both saline and silicone in a double-lumen constructs are to be placed on the market by late July 1999. Currently, saline implants continue to be the most widely used permanent implant for reconstruction.

Autologous Tissue Transfer

Latissimus Dorsi

The second most common technique for breast reconstruction has been the use of autologous tissue to reconstruct the breast mound. Several nearby tissue transfers can be used. These transfers may be performed by rotating tissue on a vascular pedicle ("pedicled" flap) or re-attached via microsurgery ("free flap") to locally available vessels such as the thoracodorsal or internal mammary. The use of the latissimus dorsi myocutaneous flap, introduced in the late 1970s, offered an alternative to implants and produced a more natural-appearing breast. This flap transfers the latissimus dorsi muscle and a paddle of overlying skin, which is used to replace the breast parenchyma. Due to the thin nature of this muscle and often sparse subcutaneous fat, however, adequate projection is often difficult and usually requires augmentation with an underlying implant. Axillary irradiation or injury to the thoracodorsal and anterior serratus vessels due to aggressive axillary dissection may lead to flap failure. Shoulder and arm function is usually minimally affected. Surgical harvest also results in a long donor scar that may result in a depression on the patient's back. The major disadvantage, however, is the need to use a prosthesis to augment the projection of this flap.

Transverse Rectus Abdominis Flap

In the early 1980s, the search for additional autologous tissue options was rewarded by the

development of the transverse rectus abdominis myocutaneous (TRAM) flap, which provides not only abundant skin for added projection, but also the soft tissue needed to fashion a breast mound with more natural ptosis. In most cases, an underlying prosthesis is not necessary. This flap takes advantage of the natural infra-umbilical fat pad found in the lower abdomen of most women. A transverse paddle of skin normally discarded in the classic abdominoplasty ("tummy tuck") is maintained by the vascular pedicle that passes through the rectus abdominis muscle. The ideal candidate is a patient with skin laxity of the lower abdominal wall who would benefit from an abdominal lipectomy and who also is properly motivated.

Anatomy and Design. The rectus abdominis muscle is supplied by two pedicles; the superior epigastric from the cephalad direction and the inferior epigastric from the rostral direction (Figure 2A). Musculocutaneous perforators travel through the rectus muscle up into the overlying skin and subcutaneous tissues. The greatest number of cutaneous perforators are centered in the periumbilical area. The transverse skin island must, therefore, always include the skin surrounding the umbilicus. While the skin and subcutaneous tissue around the umbilicus is harvested, the umbilicus itself is dissected free and left in its native position (the umbilicus is passed through and sutured to a new orifice in the superior abdominoplasty flap).

The transverse skin paddle of the TRAM flap is subdivided into four zones based on vascular supply and predictability of flap survival²⁰ (Figure 2B). The tissue designated as zone 1 has the greatest survival, since it overlies the rectus abdominis muscle. Often, the peripheral zones of skin farthest from the rectus myocutaneous perforators, such as zone 4, are poorly perfused and are discarded. In most cases, the contralateral muscle flap is preferred, since it produces less twisting of the muscle and potential kink of the pedicle through the thoracic tunnel.

Although the deep inferior epigastric pedicle has been shown to be the dominant vascular supply to this transverse skin territory, the superior epigastric vessels are able to supply

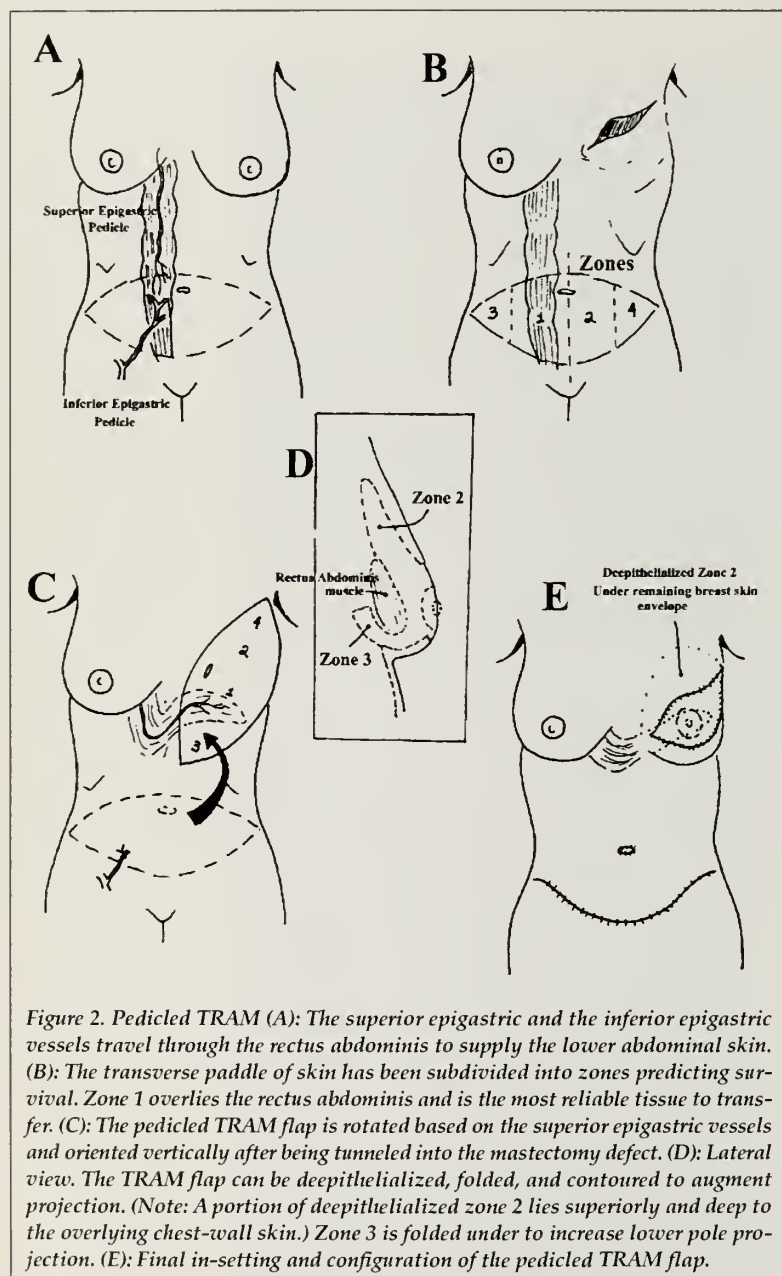


Figure 2. Pedicled TRAM (A): The superior epigastric and the inferior epigastric vessels travel through the rectus abdominis to supply the lower abdominal skin. **(B):** The transverse paddle of skin has been subdivided into zones predicting survival. Zone 1 overlies the rectus abdominis and is the most reliable tissue to transfer. **(C):** The pedicled TRAM flap is rotated based on the superior epigastric vessels and oriented vertically after being tunneled into the mastectomy defect. **(D):** Lateral view. The TRAM flap can be deepithelialized, folded, and contoured to augment projection. (Note: A portion of deepithelialized zone 2 lies superiorly and deep to the overlying chest-wall skin.) Zone 3 is folded under to increase lower pole projection. **(E):** Final in-setting and configuration of the pedicled TRAM flap.

the lower abdominal soft tissue and comprise the blood supply for the pedicled transverse rectus abdominis flap. By dividing the rectus muscle inferiorly (along with the inferior epigastric vessels), the TRAM flap may be rotated and tunneled into the mastectomy cavity based on the superior pedicle (Figure 2C). A vertical orientation is the most frequently used method to tailor the flap into a breast mound. Portions

of the flap can be deepithelialized and folded over to adjust projection, width, height and contour (Figure 2D and 2E). When larger flap tissue requirements are needed to reconstruct a large breast, double muscle flaps or free flap reconstruction is used to ensure more reliable transfer of tissue.

Healthy patients with a mildly protuberant lower abdominal wall are ideal candidates for a TRAM reconstruction. Previous abdominal incisions, however, such as subcostal incisions may have divided the rectus abdominis and the superior epigastric vessels obviating a pedicled flap, whereas lower quadrant incisions affecting the inferior epigastric vessels may prevent a free TRAM. If previous abdominal scars prevent the use of the contralateral muscle, the ipsilateral may be used. In addition, patients with a thin abdomen may not have enough abdominal tissue to perform a TRAM. In such situations in which implants are not an option, other autologous sources such as the latissimus dorsi or one of many free flap options may be considered.

Abdominal wall reconstruction is performed after transfer of the TRAM flap, since a significant portion of the anterior rectus sheath as well as the rectus muscle is harvested. If adequate abdominal fascial laxity exists, the resulting defect can be closed primarily. In the common event that this is not possible, many surgeons use synthetic mesh for reinforcement to prevent future hernia formation.²¹

Advantage of TRAM Flap. The major advantage of autologous TRAM breast reconstruction is the greater ability to produce a more natural-appearing mound, particularly in those women with large mature ptotic breasts (Figure 3). Another advantage is the ability to preserve the intact IMF by placing the flap tissue in a subcutaneous pocket rather than under muscle. In addition, the need for a prosthesis is essentially eliminated, and the patient often benefits from an abdominoplasty. Not infrequently, the patient focuses on the benefits of an improved lower abdominal contour, which helps to offset the emotional trauma of her cancer reconstruction. Furthermore, the patient



Figure 3. Pedicled TRAM flap in a 48-year-old woman after mastectomy for breast cancer. (A): Paget's disease of right nipple with preoperative markings for pedicled TRAM. (B): Three-week postoperative views after skin-sparing mastectomy. Note the circle of lighter skin representing the TRAM flap on the reconstructed right breast where the nipple-areola was resected. (C): Six-month postoperative views after liposuction, scar revision, and nipple reconstruction. (D): One-year postoperation after nipple areola tattoo. Note the slight gain in weight of the patient on the lateral view.

does not need frequent postoperative visits as with tissue expansion. The literature suggests a lower revision rate of TRAM reconstructions compared to expansion and implants.⁶ Nevertheless, many patients after TRAMs still require contralateral breast contouring for optimum symmetry.

Disadvantages and Complications of the TRAM Flap. The major disadvantage of a TRAM reconstruction is that it is a procedure of greater magnitude with an increased operative time, often 2 to 3 times longer than the mastectomy. Recovery time is also increased, since the patient must recuperate from the mastectomy and an abdominoplasty incision. As with an abdominoplasty, patients will need 6 to the 8 weeks to fully return to preoperative activity

levels. There is an increased risk of hernia formation (3.3% to 5%) and a higher risk of minor wound complications, such as fat necrosis in the TRAM flap, often requiring secondary revision.^{21,22} Contraindications to the TRAM include thin patients or those with medical conditions precluding prolonged operative times. As previously stated, relative contraindications include smoking, diabetes, and obesity. These conditions are associated with an increased risk of partial or complete flap failure due to compromised vascularity. Often, these situations can be overcome by preconditioning of the flap with a "delay procedure," double pedicle flaps, or a free flap. Abdominal hernia or abdominal flap necrosis can be avoided by careful operative technique and judicious use of synthetic mesh.

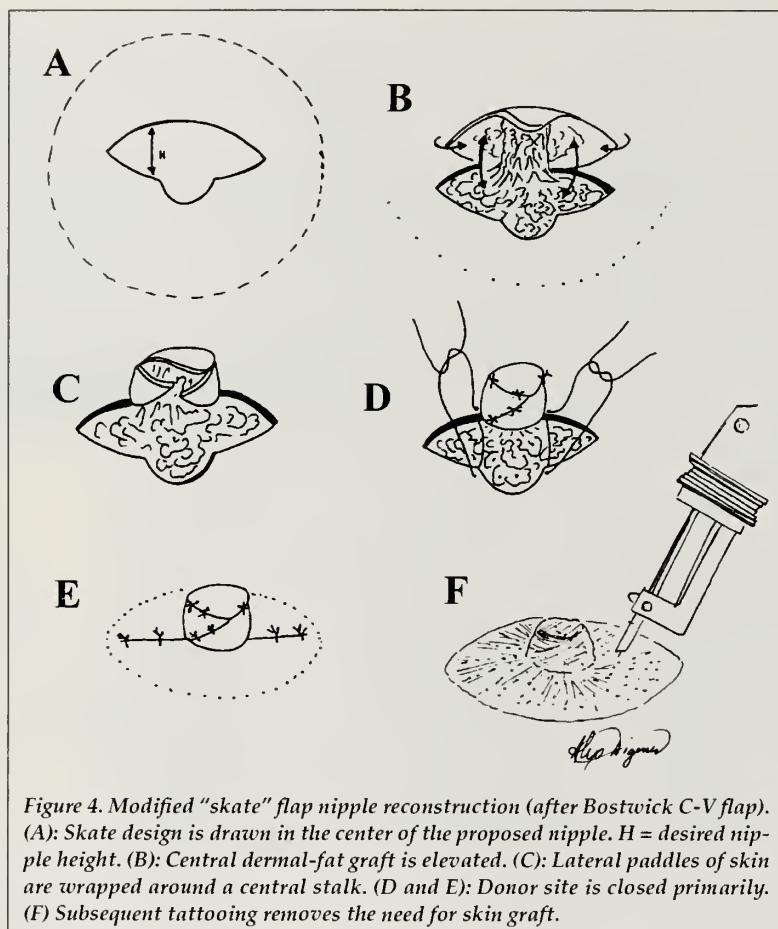


Figure 4. Modified "skate" flap nipple reconstruction (after Bostwick C-V flap). (A): Skate design is drawn in the center of the proposed nipple. H = desired nipple height. (B): Central dermal-fat graft is elevated. (C): Lateral paddles of skin are wrapped around a central stalk. (D and E): Donor site is closed primarily. (F) Subsequent tattooing removes the need for skin graft.

Microvascular Breast Reconstruction

Microvascular breast reconstruction with the TRAM flap based on the inferior epigastric vessels may be used as an alternative to the superior pedicled technique. The rectus is divided completely, and the inferior pedicle is anastomosed microsurgically to the thoracodorsal vessels. This anastomosis is performed under a microscope or loupe magnification. This type of transfer may be indicated in patients with previous subcostal incisions potentially interrupting the superior pedicle. Proponents of this technique suggest a decreased potential for postoperative abdominal hernia formation due to a smaller amount of muscle harvested.²¹ The free TRAM is believed to allow more predictable tissue transfer and have less fat necrosis. Several studies, however, have not shown any significant aesthetic advantage when com-

pared to the pedicled technique.²³ A microsurgical anastomosis may also be performed secondarily if a superior pedicled TRAM appears to show signs of ischemia or venous congestion. Such a "supercharging" is rarely needed, but is an important option for the infrequent flap that develops perfusion problems.

If a free TRAM reconstruction is not possible, then other donor site options may include tissue from the buttock based on the gluteal vessels or hip soft tissue based on the deep circumflex iliacs. These alternatives are more difficult technically and are usually inferior to the TRAM flap in providing adequate tissue bulk.

Nipple-Areola Reconstruction and Secondary Revisions

A second procedure is usually performed to both sculpt the breast mound as well as reconstruct the nipple-areola complex. Nipple reconstruction and liposuction, as well as direct fat excision, may be performed to contour the breast. These procedures may be performed under local sedation and as an outpatient procedure. Several methods are used depending on the size of the opposite nipple and the preference of the surgeon. These techniques vary from composite grafts of the ear lobule to local dermal fat flaps made from the skin of the reconstructed breast. The most popular of these techniques is the "skate" flap, which represents a raised cone of skin and fat that is wrapped with lateral skin paddles (Figure 4). In the past, the skin around the nipple cone was skin grafted with darker pigmented skin from the inner thigh or labia. Tattooing, which allows placement of a color-matched intradermal pigment directly on the breast mound, has improved areolar coloration and decreased the need for skin grafting. Tattooing is now commonly performed in the plastic surgery office under local anesthesia with excellent results.


CONCLUSIONS

These new refinements in techniques as well as prosthetic devices provide a number of options

for breast reconstruction in the postmastectomy patient. The appropriate technique must be determined based on medical history, anatomy, patient preference, and a thorough exchange of options with the patient and her reconstructive plastic surgeon.

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THE RIGHT TO REFUSE PSYCHIATRIC TREATMENT IN KENTUCKY

Michael R. Harris, MD

During the last 30 years, involuntarily committed psychiatric patients have utilized the justice and legislative systems to delineate their legal rights to refuse treatments prescribed by their psychiatrists. In this paper, the legal and medical implications of the right to refuse psychiatric treatment in the Commonwealth of Kentucky are reviewed. A brief history of the legal precedents is presented, followed by a review of studies on the impact of these developments on patient care. The specific laws and regulations of Kentucky in this area are then reviewed. Approaches to the treatment-refusing patient are then discussed, with emphasis on using a cooperative approach with refusing patients and maintaining a positive doctor-patient relationship. The process of obtaining court-ordered treatment on patients is then reviewed, with emphasis on the legal and clinical implications of this decision and suggestions for psychiatrists who feel that this approach is warranted.

Although society has for many years extended to psychiatrists the right to hospitalize a mentally ill patient without their consent, since the 1970s, courts and legislatures have given these patients previously unrecognized rights to refuse treatment. On the surface, this may seem contradictory: why would society have an interest in depriving a mentally ill patient of their liberty, but not an interest in making that same patient well so that they can return to freedom? However, the doctrine of dangerousness or harm, usually based on a physician's judgment and used to determine a patient's need for involuntary hospitalization, is not the same as the doctrine of competence, which is a legal judgment made in a court of law. In other words, the fact that a patient is committed involuntarily for psychiatric care does not necessarily mean that the patient is globally incompetent to make treatment decisions. This

contradiction, so confusing to psychiatrists, is the basis of the right to refuse treatment.

The Commonwealth of Kentucky, as with many states, has enacted legal statutes that specifically address these issues in the psychiatric patient population. This paper will review the history of the right to refuse treatment, some of the key court cases relevant to this topic, and the manner in which this issue has been addressed by the Legislature and Courts in Kentucky. We will also review the options available to patients and their psychiatrists when agreement on appropriate treatment is not forthcoming. It should be noted that this discussion applies only to patients who have been involuntarily committed to a hospital or other treatment facility; voluntary psychiatric inpatients are judged to be globally competent to make treatment decisions regardless of their physician's advice.

RIGHT TO REFUSE TREATMENT: HISTORY

Prior to the 1970s, few states had laws that restricted the right of a psychiatrist to treat an involuntarily committed mentally ill patient without their consent. In fact, the *Youngberg v Romeo* decision by the United States Supreme Court¹ specifically emphasized that institutionalized patients have the right to receive appropriate treatment, and established professional judgment as a standard to which courts should defer. Then in April 1975, a group of patients at Boston State Hospital filed a lawsuit in Federal District Court that became known as *Rogers v Commissioner of Mental Health*, or simply *Rogers*.² The suit protested the traditional policy of medicating patients without their con-

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sent, and argued that in spite of mental illness the patient continued to retain a Constitutional right to determine what could and could not be done to them based on the proscription of cruel and unusual punishment contained in the Eighth Amendment. At trial, *Rogers* was decided in favor of patients' rights, with high emotion on both sides of the issue. Psychiatrists feared that state hospitals would become "dumping grounds," filled with patients that would simply waste away in the back wards. Legal advocates for patients' rights felt that strengthening the patient's right to refuse treatment was the only way to insure treatment with dignity for the mentally ill and to insure quality care in the state hospitals.

In 1981, the Commonwealth of Kentucky addressed the issue of forced treatment in *Gundy v Pauley*.³ In *Gundy*, the Court of Appeals refused to allow involuntary treatment with electroconvulsive therapy in a patient who, although involuntarily committed, had not been found to constitute an immediate threat to herself or others, and who had not been declared incompetent by a court. Following this decision, legislation was enacted to specify a patient's right to refuse treatment, and the process of appeal open to psychiatrists who wish to pursue forced treatment with medications or ECT. This statute, and the resulting administrative procedures, will be the focus of a later section.

RIGHT TO REFUSE TREATMENT: MODELS

Appelbaum⁴ has described two basic models of the judicial basis of the right of a patient to refuse psychiatric treatment: the *treatment-driven* model and the *rights-driven* model.

The basis of the treatment-driven model is that the patient's rights are generally limited to the right to receive appropriate psychiatric care, the need for which is determined by the physicians based on clinical judgment, regardless of the patient's wishes. In its most basic form, this was the "paternalistic" model that existed prior to the 1970s. A variation of the treatment-driven model includes some additional safeguards by

insisting on independent clinical review of the treatment's appropriateness prior to forced treatment. However, this model still denies even competent patients the right to make the final decision about their own care. These concerns led to the development of the rights-driven model.

In the rights-driven model, the patient is considered to have the right to have a significant degree of control over the treatment they receive regardless of the physician's recommendations. The legal presumption in these cases is that the patient's stated wishes are accurate reflections of the patient's true intent, and that these wishes correspond to the patient's attitudes and values that remain relatively constant over time. This view usually contrasts with the physician's viewpoint in the case of psychotic patients, in which psychotic reasoning, oppositional attitudes, or mere whim appear to guide the patient's decisions. In the interest of providing for citizens the full rights to which they are entitled, many state legislatures have adopted statutes that accord with the rights-driven model. In the current legal climate, many psychiatrists will be faced with involuntarily committed patients who refuse to accept prescribed treatment, and will be confronted by the choice of legal action, negotiation with a psychotic or unreasonable patient, or allowing a patient to go without treatment.

THE PRACTICAL OUTCOMES OF THE RIGHTS-DRIVEN MODEL

In the aftermath of *Rogers*, Hoge et al⁵ conducted a prospective study at four state mental hospitals in Massachusetts to examine the impact of the right to refuse treatment on the hospital course of acute psychiatric patients. From a sample of 1484 patients admitted during a 6-month period, 103 patients actively refused psychotropic medication for more than 24 hours. Demographic characteristics of medication-refusing patients ("refusers") were not significantly different from control patients, although it was noted that refusers were somewhat more likely to lack medical insurance and

to be alienated from medical and social support systems in their communities. The refusers had significantly higher levels of psychosis and grandiosity, as measured by standard scales, were more likely to require seclusion or restraint (physical or chemical), and were more often found to be threatening or assaultive on the unit. In addition, unit staff reported a significant negative effect on the unit milieu caused by these patients.

When questioned, the largest subset of refusers cited side effects of antipsychotic medications as their reason for refusal; fewer patients cited ineffectiveness of medication, denial of mental illness, or responses that indicated idiosyncratic or psychotic thought processes. Interestingly, the clinicians reported that they believed bizarre thought processes or interpersonal issues were the probable causes of the refusals, and only 5% of the clinicians thought that medication side effects might be the primary cause.

A significant finding reported in this study is that 55% of treatment refusals were eventually resolved with voluntary compliance, with most patients claiming improved insight into the benefits of medication treatment. The next largest subgroup said that gaining some secondary objective, such as discharge or increased privileges, was their motivation. For other patients, negotiation between the patient and doctor (for example, medication dosage adjustment or mood stabilizing medications as opposed to antipsychotics) resulted in acceptance by the patient of the treatment, even if considered suboptimal by the psychiatrist. Of the 45% of refusers who never accepted voluntary treatment, 23% never received antipsychotic medications and were either treated by other methods or discharged without medication. Only 18% eventually went before a judge to face involuntary medication, and every one of these patients was eventually court-ordered to receive treatment.

A study by Schwartz et al⁶ found that the majority of patients who received involuntary medication felt that their involuntary hospitalization and treatment had been proper and beneficial. Those patients who disagreed with these

assertions on discharge were noted to have high levels of grandiosity, denial of illness, and responded poorly to treatment. This study, and others, are presented as arguments for a return to the predominance of the treatment-driven model, since they suggest that refusal of treatment is frequently the result of transient psychotic or impulsive states. But these studies have not overcome the concerns of state legislators, who have tended to enact legislation more in sympathy with the rights-driven model, forcing psychiatrists to justify their treatment plans in a court of law.

KENTUCKY LAWS AND REGULATIONS REGARDING THE RIGHT TO REFUSE TREATMENT

In 1982, the Commonwealth of Kentucky enacted Chapter 202A of the Kentucky Revised Statutes (KRS 202A), which deals with the mentally ill and mentally retarded. Sections 191 and 196 of this law are directly relevant to the right to refuse treatment, and regulations that implement these laws have been published as Kentucky Administrative Regulations, Title 908, Chapter 3, Section 010 (908 KAR 3:010). To understand the rights and responsibilities of both patient and physician, these laws will now be reviewed in some detail.

In KRS 202A.191, the law states that, among other rights enjoyed by the involuntarily hospitalized mentally ill, all patients have "[T]he right to refuse treatment subject to the provisions of KRS 202A.196."⁷ KRS 202A.196 outlines the procedures that a hospital or other treatment facility must follow in their attempts to force a patient to accept medication or treatment against their will.⁸ A three-member committee of qualified mental health professionals is appointed by the hospital director to review the patient's treatment plan and determine if it is appropriate, and then to meet with the patient and the patient's legal counsel within 3 days. If the committee and patient cannot reach an agreement on proceeding with treatment, the hospital then has the option to file a petition in District Court for a "de novo" determi-

nation of the appropriateness of the proposed treatment. A hearing is then held, within 7 days, and the judge is charged to consider the following:

- a. Is this treatment necessary to protect this patient or others from harm?
- b. Is this patient capable of giving informed consent to this treatment?
- c. Is any less restrictive treatment available?
- d. Does this treatment carry a risk of permanent side effects?

If the court finds that the treatment is appropriate, an order is issued to treat the patient despite their refusal. This process and the standards by which these judgments are to be made were challenged in the Court of Appeals of Kentucky by Edward Messer, a patient at Eastern State Hospital, and were found by the court to be constitutional and appropriate (*Messer v Roney*, 1989).⁹

In the absence of a "de novo" treatment order, the physician may treat the patient against their will only in an emergency situation. The regulations (908 KAR 3:010) define "emergency situation" as "the presence of a situation in which a patient's behavior in his present environment is such that it presents an immediate and substantial danger or threat of immediate or substantial danger to that person or to others."¹⁰ It should be noted that the regulations expand on this definition to include verbal threats or abuse that may cause *other patients* to act in a way that threatens their or someone else's safety, or any behavior that interferes with other patients' ability to benefit from their hospital stays. It also includes significant or repeated violence, disruptive behavior, or violation of an agreed treatment plan, with the stipulation that the patient had agreed to the treatment plan prior to its implementation.

APPROACHES TO A PATIENT WHO REFUSES MEDICATION

In the previously cited study, Hoge⁵ noted that determination of which patients are "medication refusers" depended partly on your time

frame. Most patients who met that study's criteria for medication refusers began to refuse medication within 72 hours of admission, but 55% of those patients then accepted medication within a week, predominantly through the interventions of staff members who were able to convince the patients of the benefits of medication. An important issue, frequently overlooked, is the patient's fear of medication side effects as a result of prior experience with the medication. In a 1987 study, Weiden et al¹¹ noted a high rate of clinical nonrecognition of extrapyramidal syndromes that could be detected by standardized evaluation instruments such as the Acute Involuntary Movement Scale (AIMS).¹² Due to the prominence of this concern in medication-refusing patients, the psychiatrist is clearly well-served to increase his or her index of suspicion for EPS, especially tardive dyskinesias that involve extremity movements or akathisia that may be interpreted as "acting out" or "restlessness and agitation." Adjustment of antipsychotic dose or medical side effect management may be points of negotiation between refusing patients and their doctors. Such negotiation not only accomplishes the physician's goal of appropriate treatment, but strengthens the doctor-patient relationship with positive effects on compliance and prognosis.

In a minority of patients, persuasion and negotiation are not sufficient to obtain consent for treatment. At this point, the physician must carefully consider his or her options. It may be that the treatment plan could be carried without medication, through behavioral interventions or supportive psychotherapy. Use of a medication without adverse associations for the patient, such as a mood stabilizer, may be considered in lieu of optimal treatment with antipsychotics. Certainly any patient who has had negative experiences with traditional antipsychotics should be offered a trial of a newer atypical medication; these have fewer risks for short-term side effects as well as for long-term effects such as tardive dyskinesia. If the advantages of the new medication are explained in

the context of the patient's ability to benefit from treatment, and sufficient "personal space" and time provided for the patient to consider their decision, this approach may have considerable success with otherwise reluctant patients.

If the psychiatrist feels strongly that medication is required for this patient, but the patient continues to refuse, the "de novo" process can be instituted through the court system to force the patient into compliance. Any psychiatrist considering resort to this option must note several important points.¹³

- A specific treatment plan must be proposed to the court, including which medications will be given for treatment, side effect management, and emergency physical or chemical restraint. The court order, if issued, will contain only that treatment plan proposed to the court in the initial filing, unless the judge feels compelled to modify the plan in consultation with the physician or on their own. It is especially important to include the maximum possible dosage of each medication and the purpose of each medication in the treatment plan.
- The physician must be ready to explain why this treatment will protect the patient and/or others from harm, why they are capable or incapable of giving informed consent, why medication is necessary in the treatment plan (why not just psychotherapy or milieu therapy), and the risks of permanent side effects.
- In the area of side effect risk and management, the court and patient's counsel will expect the physician to "make a case" for each medication in spite of possible adverse effects. To be complete, the physician should remember to include severe adverse reactions such as agranulocytosis and neuroleptic malignant syndrome in the list, as well as their plan for monitoring for these conditions and treating them if they arise.
- The patient will be provided with counsel, and has the right to challenge the physician's plan in court. Among other topics, the constitution of the review committee and their evaluation and decision process may be

examined in court. This underscores the importance of appointing a review committee that has no apparent conflict of interests or predisposition to "rubber stamp" the treating physician's plan due to staff loyalty, economic interests, etc.

- The judicial review process will increase the length of the patient's hospital stay. In the study by Hoge, a mean of 36.7 days elapsed between the patient's refusal of medication and the hearing for involuntary treatment. In addition to lengthening the hospital stay, the application for forced treatment may cause the doctor-patient and staff-patient relationships to deteriorate even further as both sides suffer the consequences of extended hospitalization.
- The physician must be prepared to address the patient's concerns during the actual hearing, under examination by the patient's counsel. Many of the specific issues discussed above will be brought out in court, possibly under hostile questioning. Although the physician's concern for the patient's benefit is the paramount concern, physicians should be prepared for the emotionally difficult experience of having their professional decisions challenged in court by non-physicians.

It should be noted that, even in light of the recent emphasis of the legal system on patients' right to refuse medication, most courts are willing to grant the physician involuntary treatment authority if the physician feels strongly that the treatment will benefit the patient. For example, in Jefferson County, KY, during 1997, a total of 11 petitions for involuntary treatment were filed. Every petition that was filed and went to trial resulted in an involuntary treatment order. While this may be comforting for physicians contemplating a "de novo" hearing, it also reflects the court's trust in the professional judgment of psychiatrists.

CONCLUSION

In Kentucky, patients have a clear, unequivocal right to refuse psychiatric treatment. This right

THE RIGHT TO REFUSE PSYCHIATRIC TREATMENT IN KENTUCKY

has developed in response to concerns that the mentally ill were being deprived of the rights accorded to non-mentally ill patients under the Eighth Amendment. Although in a small number of cases this has resulted in extended hospital stays and increased physician involvement in the legal system, the majority of patients ultimately benefit from this cautious approach to psychiatric care. Significantly, when psychiatrists feel strongly that the patient's decision does not serve their best interests, and can support their argument in court, the judiciary is willing to trust the physician's judgment and accept the notion that their plan is guided by their concern for the patient's best interests. It is critical that physicians approach medication-refusing patients with tact, understanding, and patience, while not allowing psychotic or aggressive patients to come to harm or harm others. In this relatively recent, still uncertain, and highly emotional area of contact between psychiatry and the law, our patients are the ultimate beneficiaries.

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REVISITING THE ETHICS OF HIPPOCRATES IN THE SESQUICENTENNIAL OF SIR WILLIAM OSLER

To the Editor:

Sir William Osler continually pointed out to the medical profession in his writings and teachings the significance of Hippocrates, his Oath and practice. He helped every physician to have knowledge of the high ethical precepts that Hippocrates had laid down for the medical profession. Osler's appreciation for the document that had been in continual use for 25 centuries meant so much to him that he frequently mentioned it.

The Hippocratic Oath has been accepted as the highest moral statement for the practice of medicine, irrespective of religion or race. It is only in this century that The Oath has come under the greatest attack and change. Other ethical statements of Hippocrates such as "First do no harm" and "I will follow that method of treatment which, according to my ability and judgement, I consider for the benefit of my patient. . ." are no longer felt to be applicable in the face of some modern treatments and in managed care.

Hippocrates' challenge to the medical profession to purge itself of bad physicians, to many, has come under more attack from the public and legal system than from within the profession itself. Can the Hippocratic Oath be practiced in modern systems of health care delivery? For Sir William Osler and many today the ethics laid down for the profession by Hippocrates are still the highest level ever stated for a profession and civilization.

Personal views of the importance of The Hippocratic Oath, especially for sanctity of life, written in rhyme after graduation from medical school and after over four decades of practice follow:

THE HIPPOCRATIC OATH

From an ancient culture medicine gained ethics and science;
And in signs, symptoms and seasons of disease found reliance,
Not upon display of entrails of animals or heaven's starry bands,
But on what one could see, hear, taste or touch with hands.
An oath was derived from teachings of Pythagoras through Hippocrates
Representing the ethical code for medical practice for centuries.
For physicians to swear before peers, patients and Deity:

To refrain from all actions causing harm or injury,
To follow the best regimens according to judgement and ability,
To hold all learned from patients in strict confidentiality,
To honor their teachers as parents and other physicians as brothers,
To practice the medical profession and no others,
To refuse to advise or use instruments to abort or kill,
To practice the art with purity, and holiness as well,
To abstain from performing operations without qualifications,
To use no position or office to obtain sex or other relations.

With great pride and respect for this noble profession
I have vowed to live and abide by this ancient lesson.
Let all that is good for my patients be my guide;
And may no evil thoughts or actions in me reside,
As I continue to learn and practice the healing art;
For this opportunity I am grateful with all my heart.

(For Wilburt C. Davison, Dean, School of Medicine,
Duke University, North Carolina, 1957)

OATH OF HIPPOCRATES

I swear by Apollo, the Physician, and Aesculapius and health and all-heal and all the Gods and Goddesses that, according to my ability and judgment, I will keep this oath and stipulation:

CO reckon him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required: to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it, without fee or stipulation, and that by precept, lecture and every other mode of instruction, I will impart a knowledge of the art to my own sons and to those of my teachers, and to disciples bound by a stipulation and oath, according to the law of medicine, but to none others.

I will follow that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; furthermore, I will not give to a woman an instrument to produce abortion.

With Purity and with Holiness I will pass my life and practice my art. I will not cut a person who is suffering with a stone, but will leave this to be done by practitioners of this work. Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption; and further from the seduction of females or males, bond or free.

Whatever, in connection with my professional practice, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken abroad I will not divulge, as reckoning that all such should be kept secret.

While I continue to keep this oath unviolated may it be granted to me to enjoy life and the practice of the art, respected by all men at all times but should I trespass and violate this oath, may the reverse be my lot.

Postscript

For me four decades have passed, and now many physicians say
That society's needs and technology must have their way
In issues of priority, care, confidentiality, abortion and euthanasia,
Which practitioners of medicine must confront every day.
When professional opinions differ so greatly, is there need for an oath,
If so many physicians are not willing to pledge their troth?
Have we become as the unenlightened before Hippocrates?
Should industry, government or society determine patients' needs?
Medicine must always reach for the highest Quality care role,
For the highest level of moral thought and action as its goal.
The Oath of Hippocrates with its covenant and philanthropy
Shall always remain a beacon to sanctity of life for humanity.

(For Dr E. David Cook, Chaplain and Secretary, Green College,
Oxford, England, 1993)

Billy F. Andrews, MD
Louisville, KY



Kimberly A. Alumbaugh, MD

CONTRACEPTIVE EQUITY

Regardless of your politics, regardless of your religion, your profession forces you to commit to the health and well being of your patients. Many times after a diagnosis has been rendered, we ask ourselves what could have been done to prevent this unexpected, unprepared, costly, and ill-timed outcome. We wish for more patient education, because, clearly if someone understood the risks involved, the personal crisis and commitment involved, they would do anything to prevent the diagnosis if they could. Finally, when science is lucky enough to find a cure for the diagnosis, we encourage our patients to seek out the cure, yet we are amazed to find out that the treatment for this condition is not covered by the insurer, despite its nominal comparative cost in comparison to its alternatives. Breast cancer and bone marrow transplants? No—how about unplanned pregnancies and oral contraceptives?

There is really no denying that research for women's health funding has historically lagged behind men's. However, now we see efforts to right this wrong. It is certainly obvious that gender equity issues have prevailed to the point where it is hardly surprising to find 50% of the graduating medical school class is

female and almost problematic when some specialties are almost exclusively female. So why is there controversy surrounding the provision of sound medical treatment to prevent unplanned pregnancy? Clearly, this is an extreme case of S & M.

Sex and Morality are the problems here; neither of which you can easily talk about in polite conversation, both of which interweave to form the fabric of our culture. Surely, insurance coverage and payment for the medication prescribed for more women than any other, besides, possibly, prenatal vitamins or estrogen replacement therapy, should be an obvious right of female insureds. Why do they have to ask for it, let alone fight for it?

When Margaret Sanger began her push for family planning earlier in this century, women did not control their ability to conceive. In the past, family size was in the tens and teens, and maternal mortality was an unfortunately frequent occurrence. Today, many unplanned pregnancies lead to pregnancy termination. The logical conclusion to prevent both of these extreme occurrences would seem to be to provide women with the tools to prevent unplanned pregnancy. So, why don't we?

Surely, insurance coverage and payment for the medication prescribed for more women than any other, besides, possibly, prenatal vitamins or estrogen replacement therapy, should be an obvious right of female insureds. Why do they have to ask for it, let alone fight for it?

The economics of the argument clearly prevail. The cost of unplanned pregnancies is enormous, the societal costs of what happens to children of some unplanned pregnancies are incalculable and far-reaching.

This is not a budget buster. Those who would equate not covering contraception to the same reason they don't cover a "non-necessary drug" like Viagra miss the point entirely. This is not about sex, the lack of it, or the overabundance of it. Providing prescription equity with oral contraceptives is preventive health pure and simple.

Providing prescription equity with oral contraceptives is preventive health pure and simple.

The same insurers who will pay for a vasectomy, or pay for a tubal occlusion, or sometimes even pay for depo-progesterone agents won't pay for the Pill. Do their cost accounting figures really support that the cost of a pregnancy is less than 12 months at \$20-\$30 per month? Even if their cost figures did support this practice, can society? Can we?

There will be those who read this article and decry misguided attempts at social engineering. However, on the front line, I am

tired of 18 year old multi-gravidas crying in my office caught between their difficult alternatives just because the money wasn't there this month to fill the prescription that, appropriately taken, could have averted the entire mess. As physicians, we should demand that the tenets of public health and sound medical care take precedence over politics and legislated morality.

Kimberly A. Alumbaugh, MD



KMA/AMA 2000: A MEDICAL ODYSSEY

MEMBER-GET-A-MEMBER CAMPAIGN

Everyone knows that the personal approach is the most effective method of recruiting members. The impact is even greater when you make the call! The KMA/AMA Member-Get-A-Member Campaign is designed to assist you in locating and contacting non-members in your area. You may choose to recruit any physician in your area who has completed medical training and is in active practice, eg, hospital staff colleagues, alumni from your medical school, physicians in your specialty, or nonmembers in a particular target group. You will receive a Recruitment Kit containing support materials when you sign up.

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1-3 members	Waterman Pen
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10+ members	Laptop Computer or \$1500 Computer Accessory Pkg.

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Carolyn Daley

PARTNERS IN PROGRESS KMA-KMAA AMA-AMAA COUNTY MEDICAL SOCIETY— COUNTY MEDICAL SOCIETY ALLIANCE MEDICAL STUDENT AND RESIDENT— MEDICAL STUDENT AND RESIDENT SPOUSE ALLIANCE

The Kentucky Medical Association Alliance members are pleased to be members of a county Alliance, state (KMAA) and national (AMAA) Alliance. We are allied with physicians in our support for a better quality of life and health of the citizens of our counties, our state and our nation. The AMAA field director for the KMAA, Judy Domescik, will attend our Fall Board Meeting on September 28. The meeting will be held at the Hyatt Hotel in Lexington, Kentucky. She will speak about the AMAA Stop America's Violence Everywhere (SAVE) program. Please join us for lunch in the Regency Room (tickets are \$20 and may be purchased from the KMAA office) when she will speak about the leadership role of

the medical family in today's society. We would welcome your attendance at a presentation by SuEllen Fried, author of *Bullies and Victims, Helping Your Child Through the Schoolyard Battlefield*. She will speak at 1:30 PM on Tuesday. Please refer to the July issue of the *KMA Journal* for more information and a complete schedule.

All spouses of KMA members are welcome to join the KMA Alliance. Annual dues are \$40 for the KMAA and AMAA. The amount of the county Alliance dues may vary. The KMAA is organized in twelve Kentucky counties: Boyd, Daviess, Fayette, Henderson, Hopkins, Jefferson, Madison, McCracken, Northern Kentucky

(Campbell, Kenton and Boone counties), Perry, Pulaski, and Warren. The Member-at-Large category is available for those who do not live in an organized county. In addition, medical student and resident spouses are encouraged to join the KMAA. Their state and national dues are \$11. The membership total for the KMAA is 1009 members. Please consider giving your spouse a gift membership in the KMAA and the AMAA for \$40/year and become a *Partner in Progress*. Dues may be mailed to the KMAA office at the KMA. The KMA Alliance appreciates your partnership and support.

Carolyn B. Daley
KMAA President

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Louisville, Kentucky 40222-6301

Stamping Out Breast Cancer



The Breast Cancer Research stamp introduced last July by Hillary Rodham Clinton and Postmaster General William Henderson is a "semipostal stamp," meaning it costs more than basic letter postage but the profits go to breast cancer research.

The breast cancer stamp costs \$0.40 and is the first stamp to have its proceeds earmarked for research. Most of the proceeds—70 percent—will be given to the National Institutes of Health. The remaining 30 percent will be given to the medical research program at the Department of Defense. The recipients of the money were determined by 1997 legislation.

More than \$3.6 million has been raised so far, and the stamp is selling briskly. Two-hundred million stamps were printed and, after only four months, less than half remained in inventory. Henderson expects to need to print more stamps in 1999. The stamp is scheduled to sell through July 2000.

AMA Alliance Today, Spring 1999

The Kentucky Medical Association Alliance joins the American Medical Association Alliance and the Southern Medical Association Auxiliary in promoting the use of the Breast Cancer Research stamp.

Another Year of Top-Notch HAP Winners



The KMA Alliance proudly salutes the Resident Physician and Medical Student Spouses of the Jefferson County Medical Association Alliance for being the 1999 national winner of the AMAA Health Awareness Promotion Award in the category of Resident and Medical Student Spouse! The award was presented at the AMAA

Annual Session, which was held in Chicago in June 1999. Pam Vitaz (in photo) accepted the award on behalf of the resident and medical student spouses of the Jefferson County Kentucky Alliance.



Resident Physician and Medical Student Spouses Hospitality House Pin Making Resident Spouses of the Jefferson County (KY) Medical Society Alliance

The Resident Spouses of the Jefferson County Medical Society Alliance may not be real estate agents, but they have sold more than 500 houses in the Jefferson area. In order to build community awareness and raise funds for the Hospitality House, a lodging facility for hospital patients' out-of-town family members, the resident spouses created and sold plastic pins in the shape of small houses. The pins, attached to a card with information about the house, were sold at monthly county Alliance meetings, school functions and community gatherings. In all, the house pins raised \$2,000 for the House. More importantly, the pins increased community awareness and inspired some people to become volunteers at the house.

Don't forget to **SAVE** the date for...

SAVE TODAY

Have a fund-raiser to benefit violence prevention

Sign a SAVE Proclamation

Make a friendship quilt

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Distribute buttons (not for hitting)

Hold a candlelight vigil

OCTOBER 13, 1999

The AMA Alliance encourages you to submit your SAVE projects by mail to: SAVE Projects, AMA Alliance, 9th floor, 515 North State Street, Chicago, Illinois. 60610.

NEWSMAKERS

The Health Kentucky, Inc Board of Directors recently elected its 1999-2000 officers. **William P. McElwain, MD**, Medical Director of the Emergency Department of Rockcastle Hospital, was elected President.

Dr McElwain, of Mt Vernon, has been a physician for over 40 years. He is a former Associate-Director of the Lexington-Fayette Health Department, Commissioner of Health in the Kentucky Department of Health, trustee for the Good Samaritan Foundation and Associate Clinical Professor of University of Kentucky College of Medicine's Department of Community Health. Dr McElwain is also a member of the Robert Wood Johnson Foundation National Advisory Committee, REACH OUT: Physicians' Initiative to Expand Care to Underserved Americans. Dr McElwain has served as Health Kentucky's Executive Vice-President, Medical Affairs for 15 years.

The AMA Residents and Fellows Section is composed of representatives selected from each state.

James Woody, MD, Lexington (Past President of KMA-RPS), and **Jonathan Privett, MD**, Madisonville, have been chosen to represent Kentucky. During their recent Annual Meeting, Dr Woody served as chair of the Credentials Committee, certifying the credentials in order to seat each state's representatives. He also determined that a quorum was present in order to conduct business.

ROBERT L. NOLD, MD NAMED KAFP CITIZEN DOCTOR OF THE YEAR

Robert L. Nold, Sr, MD, Louisville, has been named Citizen Doctor of the Year by the Kentucky Academy of Family Physicians. The award is the highest honor the Academy bestows upon a member nominated by his or her peers each year.

A native of Louisville, Dr Nold received his medical degree from the University of Louisville. He has served as president of the Kentucky Academy of Family Physicians and the Academy's Jefferson County Chapter. He served on the Judicial Council of the Jefferson County Medical Society and as treasurer of the Kentucky Academy for 14 years.

Dr Nold is an associate clinical professor of family and community medicine at the University of Louisville. He has been the team physician for Fairdale High School since 1969. Dr Nold received the University of Louisville School of Medicine Departmental Outstanding Alumnus Award in 1995.



Ardis D. Hoven, MD, has been named to serve on the Board of Directors of American Accreditation Healthcare Commission Utilization Review Accreditation Commission (URAC) by the AMA Board of Trustees. She will be one of only two representatives of the AMA on this Board.

URAC is a non-profit accreditation organization that develops operating and review standards to Workers Compensation Networks, Group Health Networks, 24-Hour Telephone Triage and Health Information Organizations, Credentials Verification

Organizations and other groups. URAC is governed by a Board of Directors representing all parties affected by these managed care programs, including the American Hospital Association, large employers, the National Association of Insurance Commissioners, the Health Insurance Association of America, the United Auto Workers, the National Association of Manufacturers and others.

While URAC has no overt legal authority, its accreditation standards are accepted by 30 states for programs operating

within state boundaries. Its status is comparable to the National Commission on Quality Assurance (NCQA) but with broader application.

Dr Hoven is a Delegate to the AMA from Kentucky and also serves on the AMA Council on Medical Service. This appointment is a signal honor and reflects her significant contributions to the AMA Council.

The University of Louisville recently honored faculty who have served 25 years teaching. KMA members included in that group were **Larry N. Cook, MD**, **Laman A. Gray, MD**, and **Christopher B. Shields, MD**.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

BELL

Sutin Srisumrid MD R
200 Thornaby Ridge Way
Middlesboro 40965
1967, Chulalongkorn U, Thailand

BOYD

Robert E. Hollis Jr MD FP
2211 Montgomery Ave
Ashland 41101
1984, U of Wooster, Cleveland

BREATHITT

Richard C. Gould MD AN
764 Shacks Branch Rd
Jackson 41339-9413
1983, U of Kentucky

BULLITT

Charlotte Ingwersen MD FP
170 Tanyard Way Ste 101
Louisville 40229
1995, U of Louisville

BUTLER

James T. Douglas MD FP
P O Box 1367
Morgantown 42261-1367
1995, U of Kentucky

CALLOWAY

William W. McDonald MD ONC
201S 9th St
Murray 42071
1985, Emory U, Atlanta

HARLAN

Emad H. Eskander MD P
134 Comprehensive Dr
Harlan 40831
1984, U of Alexandria, Egypt
Farooq K. Ghory MD PMR
37 Ballpark Rd
Harlan 40831
1987, Dow Med Coll, Pakistan

HENDERSON

Bassam Yousef MD IM
110 3rd St Ste 370
Henderson 42420
1986, Damascus U, Syria

HOPKINS

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200 Clinic Dr
Madisonville 42431
1973, Chicago Medical

JACKSON

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P O Box 1089
McKee 40447
1986, U of Kentucky

JEFFERSON

Lisa L. Corum MD FP
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1995, U of Louisville
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550 S Jackson
Louisville 40292
1983, Georgetown U
John C. Eldridge MD ORS
234 E Gray St Ste 364
Louisville 40202
1980, U of Louisville
Juan J. Guardiola MD PUD
VAMC
Louisville 40206
1968, U of Barcelona
Dwayne E. Johnson MD PD
2525 Bardstown Rd Ste 200
Louisville 40205-2665
1983, U of Kentucky
Ann M. Lombardi MD IM
1850 Bluegrass Ave
Louisville 40215
1985, U of Michigan
Sejal V. Pedersen MD OBG
250 E Liberty St Ste 510
Louisville 40202
1994, Northeastern Ohio U

JOHNSON

Nagi H. Abadier MD OBG
634 Euclid Ave Apt 21
Paintsville 41240
1972, Ain Shams U, Egypt
Sarah M. Belhasen MD FP
1110 S Mayo Trl
Paintsville 41240
1994, U of Kentucky

LAUREL

Jean-Maurice Page' MD ORS
1406 W 5th St Ste 302
London 40741-1617
1974, U of Montreal

LOGAN

Michael L. Resnick MD OBG
1623 Nashville St Ste 105
Russellville 42276
1971, Northwestern U

MONTGOMERY

Jack R. Perry MD IM
250 Foxglove Dr Ste 2
Mt Sterling 40353
1994, Quillen-Dishner Coll, TN

NICHOLAS

Ana Rinaldini MD IM
123 Elderberry Dr
Carlisle 40311
1986, Cordoba U, Argentina

PIKE

Surianarayanan Ambalavanan MD OTO
P O Box 2140
Pikeville 41502
1978, Madras U, India

PULASKI

David G. Elliott MD PTH
481 Hubble Rd
Eubank 42567-9581
1986, U of Kentucky

WARREN

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1215 High St
Bowling Green 42101
1978, Cooper Med Coll
James R. Davis MD P
3 Chestnut Hills Ct
Bowling Green 42104
1971, Indiana U
Jeffery W. Nemec MD OBG
825 4th St
Bowling Green 42101
1992, U of Wisconsin

WASHINGTON

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79 Bob-O-Link Drive

Springfield 40069
1987, U of Alberta

WHITLEY

Stephen K. Toadvine MD FP
2 Trillum Way, Ste 200
Corbin 40701
1987, Northwestern U

WOODFORD

Krista L. Gaines MD PD
360 Amsden Ave Ste 202
Versailles 40383
1990, U of S Alabama

IN-TRAINING

JEFFERSON

Samuil W. Fidal MD AN
Sharon B. Hernandez MD PD
Farah S. Ikram MD OPH
Kenneth A. Mook MD PMR
Stacey L. Waring MD IM
Nasser Zakieh MD PUD

1999. A 1935 graduate of Cornell University School of Medicine, Dr Sanders was a life member of KMA.

Richard A Hamilton, MD
Springfield, KY
1913-1999

Richard A Hamilton, MD, a retired family practitioner, died May 8, 1999. Dr Hamilton was a 1939 graduate of the University of Louisville School of Medicine and life member of KMA.

Charles J Bisig, MD
Louisville, KY
1920-1999

Charles J Bisig, MD, a retired general surgeon, died June 18, 1999. Dr Bisig was a 1944 graduate of the University of Louisville School of Medicine and an active member of KMA.

C William Dowden, MD
Louisville, KY
1909-1999

C William Dowden, MD, a retired internist, died June 21, 1999. A 1937 graduate of the University of Louisville School of Medicine, Dr Dowden was a life member of KMA.

L C McCloud, MD
Louisville, KY
1929-1999

L C McCloud, a retired pathologist, died July 14, 1999. Dr McCloud was a 1955 graduate of the University of Louisville School of Medicine and an active member of KMA.

OBITUARIES

John H Jurige, MD
Louisville, KY
1926-1999

John H Jurige, MD, a retired urologist, died March 23, 1999. Dr Jurige was a 1954 graduate of the University of Louisville School of Medicine and a life member of KMA.

George B Sanders, MD
Louisville, KY
1910-1999

George B Sanders, MD, a retired general surgeon, died April 14,

Certification Wound Specialist

The American Academy of Wound Management has advised that over a thousand wound care professionals have gained or are in the process of gaining Board Certification from the American Academy of Wound Management via completion and review of a portfolio of materials documenting experience and training in wound management. This portfolio or experiential method of attaining board certification in wound management ended on June 30, 1999.

After June 30, 1999, Board Certification in wound management can only be achieved via a passing score on the Board Certification Examination. The first examination has been scheduled for October 4, 1999, during the 14th Annual Clinical Symposium on Wound Care, to be held in Denver, CO. Qualified applicants for certification in wound management will be required to achieve a passing score on the examination to earn the designation Certification Wound Specialist (CWS).

The examination will be relevant to all health professionals involved in wound care, including, but not limited to, physicians, nurses, and

therapists. Multidisciplinary questions will cover the following topics related to wound management: General Knowledge, Anatomy, Pathophysiology, Diagnosis, Therapeutics, and Psychosocial.

U of L Researchers Report Improved Vision in Blind Patients Following Eye Tissue Transplants

University of Louisville researchers working with Louisville's Norton Audubon Hospital have reported successfully improving vision in two patients who were legally blind.

The team presented its findings recently at the annual meeting of the Association for Research in Vision and Ophthalmology in Ft. Lauderdale, Fla. The procedure eventually could help in treating degenerative eye diseases for which there is no current treatment, such as retinitis pigmentosa and dry macular degeneration.

Patients underwent operations to replace small sections of their neural retina with embryonic eye tissue. The surgery involves a procedure and equipment developed by the U of L team.

U of L eye surgeon and clinical surgery professor **Norman D. Radtke, MD**, associate professor Robert Aramant and assistant professor Magdalene Seiler reported successfully performing the procedure on animals in 1997. The team received approval at U of L to begin human trials in 1998.

The technique is significantly different from previously

reported tissue transplant attempts. The team developed a surgical tool that transfers whole sheets of cells to the center of the patient's visual field. The tissue sheets are laid in the eye on the tip of the apparatus, which is then retracted and withdrawn, minimizing trauma to surrounding tissue. Previous eye cell transplants primarily have been accomplished by suspending cells in a medium and injecting them into the desired transplant area.

Laboratory and early human results indicate that the transplanted tissue grows and develops into normally functioning retinal tissue. None of the five patients who underwent the procedure exhibited any signs of infection or tissue rejection. Two patients were removed from the study for unrelated medical conditions. Two patients who underwent the procedure between 4 and 6 months ago report perceiving light in areas of their visual field where they could not before. More significantly, said Dr Radtke, they do not see the light when their eyes are closed nor when the room is dark. (Many blind patients report seeing light, but they tend to see it all the time, regardless of the surrounding physical conditions.) The other patient's surgery was more recent and is still being evaluated.

Dr Radtke's group uses several tests to confirm that the transplanted cells have developed sensitivity to light.

The team is awaiting FDA approval to perform the transplant on five more patients. If results continue to be positive, patients may receive larger sheets

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of cells that cover larger sections of the retina, and surgeons may be able to transplant more of them per patient.

The treatment probably will not help patients whose degenerative eye diseases have caused large areas of scarring in the retina, Dr Radtke said.

Women's Health in Kentucky: Setting the Agenda

This year the conference **Women's Health in Kentucky: Continuing the Dialogue** is being held at the Holiday Inn in Frankfort, October 4-5, with an emphasis on preparing for the next legislative session. Gail Bellamy, President of the Rural Health Association, will present the keynote address "The Health of Rural Women in America: Issues and Answers." The

morning breakout sessions will again address a wide variety of topics with speakers from across the state. A legislative panel including Representatives Kathy Stein and Susan Westrom and Health Services Cabinet Legislative Liaison, Ann Gordon, will kick off the afternoon discussions. To register, check out the Web site for the University of Kentucky's Women's Health Center at <http://www.mc.uky.edu/cwh>. Or go directly to the entry at http://www.mc.uky.edu/cwh/womens_health_in_ky.htm. For further information, contact Janet Larson Braun at 606.257.5037 or jlbraun@pop.uky.edu.

Overview of Medicare's Medical Review Process

Physician offices may find themselves being audited or

reviewed by Medicare and told that they must pay hundreds, and sometimes thousands, of dollars back to Medicare based on such reviews. HCFA has prepared a document entitled "Overview of Medicare's Medical Review Process." This document summarizes Medicare's approach to such reviews and answers basic questions about the review process. A copy of this document is available by contacting KMA.

Understanding Medicare+ Choice

The AMA's booklet "What Is Medicare+ Choice and Where Do Physicians Fit In?" helps physicians and their patients understand the basics of recent Medicare changes. AMA members may order the booklet at no cost at <http://www.ama-assn.org/ad-com/reform.htm>.

MEETING NOTICE:

"CALL FOR PAPERS"—The 2000 International Conference on Physician Health cosponsored by the American Medical Association and the Canadian Medical Association has issued a CALL FOR PAPERS. The meeting will be held at Seabrook Island, South Carolina on March 29-April 2, 2000. For a copy of the Abstract Submittal Form contact: Elaine Tejcek, 312 464-5073; or e-mail: elaine_tejcek@ama-assn.org. Deadline for submittal is October 31, 1999.

JOIN THE AMERICAN CANCER SOCIETY IN MAKING STRIDES AGAINST BREAST CANCER

According to the American Cancer Society's 1999 *Facts & figures*, an estimated 2,700 Kentucky women will be diagnosed with breast cancer—that's over seven women a day. In 1999 alone, 700 Kentucky women are expected to lose their lives to breast cancer.

With your support, the ACS can help reduce breast cancer's devastating impact on our lives. Join thousands of breast cancer survivors, their families, friends and coworkers at the **Making Strides Against Breast Cancer** walk to be held in 36 cities coast to coast this fall.

In Louisville more than 2,000 walkers participated in *Making Strides Against Breast Cancer* last year. Your help is needed to push that number to over 3,000 walkers for this year's event. Join in the fun at the 5 K "family friendly" walk in **Louisville on Sunday, October 17, 1999 at 2 pm** at the Waterfront Park downtown. Walkers may register at the event beginning at 1 pm. To learn how you can be a part of this important community event in Louisville call 502-584-6783.

In the Cincinnati area *Making Strides Against Breast Cancer* will be held on **Sunday, October 24, 1999, at 10:00 am** at the Bicentennial Commons. Registration begins at 9:00 am. For more information about the walk in Cincinnati, call 513-891-1600 ext 343.

Mark Your Calendar Now to Attend the 37th Annual KEMPAC Seminar

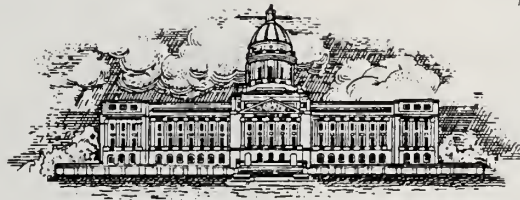
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Senate Republican Leader*



*Representative Jody Richards
Speaker of the House*



*Where: Hyatt Regency Hotel
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Lexington, Kentucky*

*Time: 6:00 PM Reception
7:00 PM Dinner (Program to Follow)*

Tickets are now available from the KEMPAC Office at 4965 US Highway 42, Suite 2000, Louisville, Kentucky 40222 (502) 426-6200. Tickets are \$30 each and seating arrangements are in tables of eight.

Clip and Mail the Following Form. **Checks should be made payable to KMA.**

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Preparation — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.

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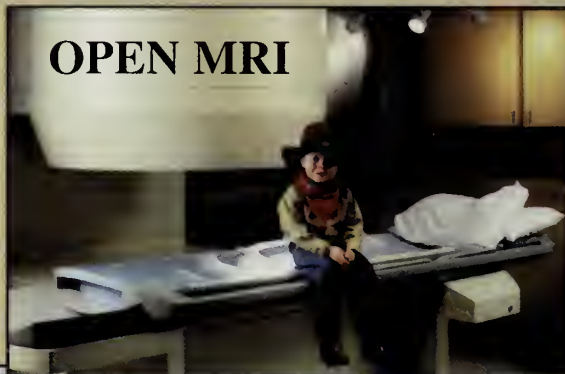


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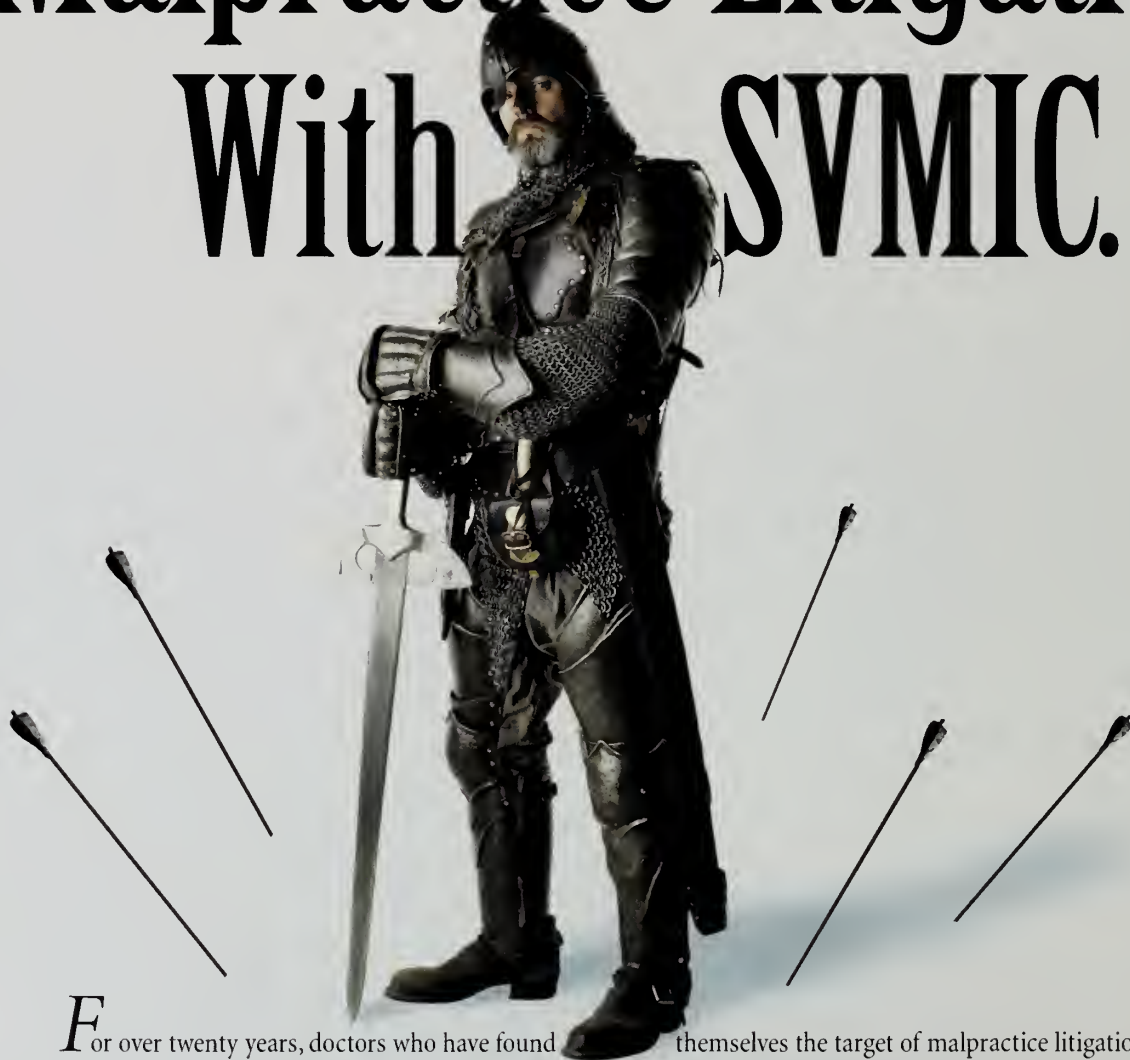
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COVER:

On September 29, 1999, Harry W. Carloss, MD, a Paducah internist/ oncologist, was installed as the 149th President of the Kentucky Medical Association. Dr Carloss's Inaugural Address begins on page 455 and a profile of this defender of medicine begins on page 482.

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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Periodical postage paid at Louisville, KY and additional offices. Yearly subscription rates: \$35 domestic; \$45 foreign. Single issues \$4 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222. Telephone 502/426-6200 Fax 502/426-6877 Email member@kyma.org

Listed in *Index Medicus*. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

EDITORIAL AND ADVERTISING: Contact Sue Tharp, JKMA, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222. Phone 502/426-6200; FAX 502/426-6877.

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Printed by the Ovid Bell Press, Inc, Fulton, Missouri 65251.

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INAUGURAL ADDRESS

BY HARRY W. CARLOSS, MD

As I reviewed the program listing the names of the past presidents of the KMA and considered their accomplishments and status, I was amazed that the society could have made such a mistake this year!

It is especially gratifying for me to be able to take office in Lexington, my hometown, at a time when we are facing the beginning of a new millennium and celebrating the bicentennial of the Fayette County Medical Society.

In reviewing events of the last few centuries, we see some things never change:

In 999, Pope Sylvester was charged with sodomy and raising the dead.

In 1999, President Clinton was impeached for obstruction of justice relating to sodomy. Viagra became popular.

In 999, people gathered to witness the end of the world.

In 1999, we await Y2K.

Other areas using technology instead of ignorance, corruption, and fear have made dramatic progress. In ancient times, people thought all life was composed of earth, air, fire, and water. In 1999, we know that life is derived from 4 chemicals:

Adenine
Thymine
Cytosine
Guanosine

Ancient Chinese used stones on an abacus to perform calculations. Today, we use silica chips to transmit, store, and assemble incalculable pieces of information.

In 1893, Thomas Hunt Morgan won the Nobel Prize in medicine for genetic experiments. In 1999, we are on the verge of completion of the human genome project and we use medications made from inserting human genes into bacteria for rapid production.

We of the KMA must use change and technology as a positive force to enhance communications, organization, and participation. We must lead the nation in adapting technology to preserve the health of our patients and the future of our profession.

Kentucky has furnished leadership in medicine in the past. Ephraim McDowell performed the first abdominal surgery on Christmas Eve 1812. Samuel Brown, MD organized the Lexington Medical Society in 1799. Dr Brown served an apprenticeship with Dr Alexander Humphreys, as did Dr Ephraim McDowell. He then trained with Dr Benjamin Rush, a signer of the Declaration of Independence. Dr Rush was perhaps the first American physician to recognize the importance of political involvement. Dr Brown then trained in Eldenbough before receiving a degree from the University of Aberdeen. A physician with a medical degree was uncommon in pioneer days as most physicians served an apprenticeship, then practiced as many trade unions do today.

The Lexington Medical Society was not only the first medical society west of the Alleghenies. It was the first society where students were allowed to participate as

members and hold office. Today the KMA and AMA are trying to encourage student participation. To accomplish this we must use technology to enhance membership opportunities for students, residents, and young physicians, reversing the national trend for nonparticipation in organized medicine by medicine's future—its youth.

I hope to report to you next year progress on enhanced electronic communication, including young physicians and students, by communicating in their language and by their preferred means of communication. By the legislative session we hope to be communicating with our members, not only by mail and fax, but by an enhanced web page and mass e-mails.

We also hope to deliver KMA and AMA policy on disk so we can all know where we stand at the touch of a key. As you past chairs of the Board know, this will be a great help to the Board of Trustees . . . where there is no shortage of opinions.

In the survey for Future Search, the strategic plan for the KMA, it became clear that legislative representation was a high priority for our members.

Our future as physicians and our patients' health is tied to our legislative efforts. This is not a change. In 1803, the Kentucky General Assembly authorized a lottery for the building of a house for the Kentucky Medical Society. Just as state lotteries are not new, neither is legislative involvement in the practice of medicine.

In 1798, the Kentucky state legislature authorized punishment for anyone bringing smallpox into the state for the purpose of vaccinations. In 2000, the KMA will ask an enlightened legislature to make Kentucky a Universal Vaccine state, thus bringing timely vaccinations to all of Kentucky's youth.

Acting on a House of Delegates initiative, your leadership has been in close communication with Governor Patton on several occasions this past year and will complete the task next year.

- Currently 46% of conventional health plans and 34% of preferred provider plans do not cover vaccinations.
- Approximately one-fourth of children under age 2 are not fully immunized when protection is most crucial.
- 27,672 reported cases of measles in 1990—18% increase from 1983. Eighty-nine of these cases resulted in death; 49 of those were children under age 5.
- In Kentucky the program would cost \$1.5—\$2 million according to the Cabinet for Human Resources.
- Under the Vaccines for Children Program, states can purchase the Oral Polio vaccine for \$2.21. In the private sector the same vaccine is \$10.47—nearly an 80% savings.
- The average cost to treat a child with Hemophilus Influenzae Type B is \$48,000. The cost to provide a child with the HB vaccine is \$16.

In 1815, Richard Carter of Versailles published a book entitled "Valuable Vegetable Medical Prescriptions for the Care of all Nervous and Putrid Disorders." In 2000, the legislators will consider various alternative medicines.

Being an oncologist, I am especially fond of harmless natural remedies. I use periwinkle, bark of the yew tree and bacterial extracts every day. Of course, I call them Vincristine, Taxol and Adriamycin, but being natural, they are perfectly harmless—right?

In 1798, a Lexington physician, Dr C. Freeman, advertised traveling through 22 different Indian tribes to investigate herbs, roots, and plants to incorporate them into his practice. In returning to natural treatments we forget that most American Indians succumbed to smallpox, a disease that modern medicine has wiped out in our lifetime.

Managed care and patient rights are not new issues. In 1935, the Lexington Clinic contracted with postal employees who paid a flat monthly fee for medical coverage. We should work to break monopoly or monopsony power of insurance carriers. Physicians,

not insurance companies, should determine medical necessity. We should not be slaves to their unreasonable systems of precertification. Insurers should be held accountable for their decisions, and physicians should have the right to collective negotiations with these agencies. Third parties should be forced to make timely payments, and should establish external independent review for contested decisions. All or nothing clauses should be banned from physicians' contracts with insurance carriers.

We should closely monitor states that have enacted a state action doctrine. These laws allow groups of physicians to negotiate with insurers, however they require that the state become a party in the negotiations. We must make sure that the risk of the insertion of the state in these negotiations does not outweigh the benefit of the ability to negotiate.

We should continue our role as guardians of public health and safety by:

- Insuring adequate funding for streamlined health departments
 - Mandating health education for school children
 - Improving the deplorable teen pregnancy rate by awareness and prevention programs
 - Mandatory bike helmets for children under 16
 - Personal watercraft safety legislation
 - Farm safety legislation
 - Pick-up truck passenger safety
- Tobacco settlement money—In the 1798 smallpox law, the judge was given power to extract "tobacco or money" to enforce the statute. Then, as now, the most addictive thing about tobacco is the money. Everyone wants part of this settlement. The KMA has developed a position statement for approval

of the House at this meeting. Since an extra 2% of our gross incomes were extracted to cover the Medicaid shortfall, we feel we have special interest in the dispersion of these funds and that 50% should go to expand coverage of Kentucky's uninsured. This money would be available for a 3:1 match of federal funds. We must be the voice of reason and compromise in this debate.

There are many other topics that will come up during this session. Dr Montgomery, Chair of the State Legislative Committee, will need your advice and support. We will keep you informed through fax or e-mail and urge you to keep in touch with your legislators and support KEMPAC. As with our state motto, "United we stand, divided we fall."

We are guilty of not changing unattractive habits also. In 1817, Dr Dudley challenged Dr Drake of Lexington to a duel over autopsy results. Dr Richardson acted in Dr Drake's behalf and was seriously wounded.

We must put aside our petty quarrels and stand up for our patients and our profession. If we do not stand up for those less fortunate, uneducated, or unhealthy—who will? This is Asclepias, son of Apollo, a famous and talented physician. Respected by all until a wealthy merchant died and he was persuaded to use his talents in exchange for money to revitalize him. He did, thus angering the gods, losing his talents, and his respect.

I guess my grandmother was right—the more things change, the more they stay the same.

— Presented by
Harry W. Carlross, MD
as he assumed the
Presidency of the
Kentucky Medical Association
on September 29, 1999.

American Medical Association Organized Medical Staff Section (AMA-OMSS)

invites your medical staff to be represented at the

1999 Interim Assembly Meeting, December 2-6, in San Diego

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OMSS representatives can:

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- Participate in special issue forums.
- Network at state and regional caucuses.
- Attend education programs. (*Topics include: managed care contracts, new CPT codes and software, preventing and managing adverse outcomes, improving physician image through community involvement, protecting your practice from embezzlement, conflict of interest policies, technology and medical staff reengineering, ways to be an effective agent for change, reestablishing collegiality in the medical profession, and federal and state legislative affairs.*)

For more information on how to register, call 800 262-3211 and ask for the Department of Organized Medical Staff Services or e-mail us at omss@ama-assn.org.

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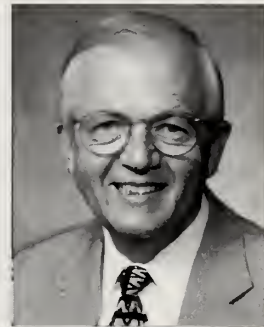
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NEWS FOR KENTUCKY PHYSICIANS

State Legislative Committee Report Wally O. Montgomery, MD, Chair



As we move toward January and the convening of the 2000 Kentucky General Assembly, the following report is submitted. The report summarizes activities of the KMA Legislative Committee, KMA Board of Trustees, and staff in moving KMA's legislative agenda forward. With the historical and dramatic shift in the Kentucky Senate from a Democrat to a Republican majority, we can expect numerous changes in leadership and Committee chairs. The overall impact of these changes, especially as they relate to individual issues, is still up in the air. First, there remains essentially a "one vote" majority on "party political" issues. One member of the majority party may "bolt" and create another gridlock. Secondly, on individual legislative proposals, most legislators' philosophical "bent" will not be altered by this change. Thirdly, while Republicans have a slim one-vote majority in the Senate, nonetheless the House remains 65-35 in favor of Democrats,

bolstered by a powerful Democrat Governor and his Administration.

KMA has established several goals for the 2000 Kentucky General Assembly which are included in this report. In addition, we are providing a brief progress report on major legislative efforts.

- **Tort Reform**—Legislation is prepared and will be introduced to amend the Kentucky Constitution to permit the General Assembly to place a limitation on non-economic awards
- **Independent External Review**—Legislation has been prefiled to address Patient/Physician concerns. In addition, several other legislators are expected to file similar legislation.
- **Prompt payment**—KMA is working with the Kentucky Hospital Association on landmark legislation to require prompt payment, define "clean claims," and require annual published audits of

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health insurers, outlining their "payment to providers" history.

- **Prohibition of "all or nothing" clauses**—Legislation has been drafted by our sponsor, and will be introduced at the appropriate time.
- **Accountability for medical decisions**—Legislation has been drafted, and the bill will be pre-filed in the near future.
- **Universal Vaccine**—We have held several meetings with the

Governor, Legislative leadership, Secretary of CHR, and Commissioner of Health seeking inclusion of approximately \$1.5 in the administrative budget to make Kentucky a "Universal Vaccine State"

- **Health and Safety Legislation**—The KMA will support legislation to:
 - Require all cyclists to wear helmets

- Prohibit minors from riding in open trucks on public thoroughfares
- Strengthen boat and water safety
- Amend statutes to provide conviction for DUI when BAC exceeds 0.08
- Mandatory health education K-12
- Mandate 50% of Phase I of the tobacco settlement goes to health care funding.

GOALS FOR THE 2000 KENTUCKY GENERAL ASSEMBLY

PATIENT PROTECTION/ PROVIDER FAIRNESS

During the 2000 Kentucky General Assembly (KGA), the KMA plans to enhance the Patient Protection-Provider Fairness provisions enacted during the 1998 KGA, by recommending the adoption of the following initiatives.

- **Independent External Appeals**
Independent external appeals programs should be established to provide an independent medical necessity or appropriateness of service review of final decisions by insurers to deny, reduce, or terminate benefits. Physicians practicing in the same state as the insured who is appealing should determine appeals. Physicians involved in the review process should be

independent of the carrier. Physicians, who act without malice or fraud and within the scope and function of the review process, should be immune from liability for decisions rendered. The cost of external appeals should be borne by carriers.

- **Prompt Payment**
Managed care plans or licensed insurers must pay a written claim submitted by physicians within 30 days of receipt of fully documented clean claim. Insurers should be required to notify physicians within 30 days if a claim is inadequately prepared. Otherwise the claim is presumed valid. Payments for electronically filed claims should be paid within 15 days. If plans fail to remit payment as required, interest may accrue at 12% per annum

added to the amount owed on the fully documented clean claim. The KMA recommends that the Department of Insurance adopt regulations that define a "clean claim." The law would apply equally to all third-party payers, including those under ERISA exempt plans, and statutes should be rigidly enforced.

- **All or Nothing Clauses in Managed Care Contracts**
Prohibit managed care networks from tying arrangements that require, by coercion or intimidation, physicians to agree to participate in all health care or managed care plans operated by the insurance company or managed care entity. Under these arrangements, in order for a physician to participate in one or more plans operated by the

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company or managed care entity, they must participate in all operable and future plans the company markets. Physicians should be free to choose the plans or policies in which to participate, and the choice should not be grounds for denying participation in any chosen plan or policy.

- **Definition of Medical Necessity**

Only physicians should determine medical necessity. Medical Necessity is clearly defined as health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms:

- (1) In accordance with generally accepted standards of medical practice
- (2) Clinically appropriate in terms of type, frequency, extent, site and duration
- (3) Not primarily for the convenience of the patient, physician, or other health care provider

- **Exclusive Contracts**

HMOs should be prohibited from offering contractual provisions which prevent physicians from becoming a participating provider on a panel outside of the HMO he or she has contracted with (prohibits physicians from

being locked onto one HMO panel).

- **HMO Contracts**

Prohibit HMOs from altering services or benefits provided during the term of the group insurance contract. Changes to covered services or benefits must be proposed at least 45 days prior to the group's contract renewal date.

- **Downcoding**

Prohibits insurers from "recoding" or downcoding a procedure submitted by a physician, on a claim for covered services provided to an insured. Insurers should be prohibited from downcoding a claim to a different classification code without meeting certain conditions. A health insurer must provide written notice to the insured and the provider that the insurer has recoded the claim, accompanied with appropriate supporting information to justify the change.

- **Accountability for Medical Decisions**

Physicians and employees of health plans and insurers should be fully accountable for demonstrated injury or death resulting from negligent medical decision-making regarding covered services. Physicians employed by third-party payers who make coverage decisions based on "medical necessity" are acting within the

professional sphere of a physician and their conduct should fall within the purview of the Board of Medical Licensure.

- **Mandatory Hospitalist Programs**

Mandatory hospitalist programs should be prohibited. Some plans are denying patients the right to have their personal physician care for them in the hospital by establishing mandatory hospitalist programs. Mandatory hospitalist programs require that a patient's primary care physician transfer complete responsibility for patient care to a hospital-based physician upon admission.

HEALTH AND SAFETY

- The KMA discourages the use of tobacco among all Kentuckians and supports legislation to prevent children's access, purchase, and use of tobacco.
- Drug, alcohol, and domestic abuse preventive programs and treatments should be available to citizens.
- The KMA urges passage and stringent enforcement of traffic safety legislation, including the required use of helmets by motorcyclists and bicyclists.
- The KMA urges the Kentucky General Assembly to adopt legislation that prohibits

MONITORING **Medicine**

minors from riding in open vehicles on state highways.

- The KMA urges stringent enforcement of driving under influence laws.
- The KMA supports mandatory health education (K-12).
- The KMA supports the teaching of sex education beginning in grades 5-7.
- **Universal Vaccine Program**
The KMA supports efforts to make Kentucky a Universal Vaccine State. Public school entry laws require that children be immunized against nine vaccine-preventable childhood diseases when they begin kindergarten or first grade. Prohibitive costs and lack of

insurance coverage are forcing parents to accept fragmented care for their children. The program would be financed through a budgetary request of \$1.5 to 2.0 Million for the biennium. Vaccines can then be purchased at reduced rates and provided free except for a reasonable administration fee.

- **Organ Donations**
Over 4000 patients died in 1996 awaiting organ donations. The KMA supports government, public, and private organization efforts to enhance and encourage citizen organ donations. Traditionally, organ donation programs operate under the "opt in" provision.

The Kentucky General Assembly should seriously consider "organ donor opt out programs" that require citizens above age 21 to automatically become potential donors unless they choose to "opt out."

TORT REFORM

The KMA supports an amendment to section 54 of the Kentucky Constitution that would permit the General Assembly to place limitations on **non-economic** awards. Non-economic damages include pain and suffering, loss of consortium, companionship, etc.

A Special Thank You From KMA

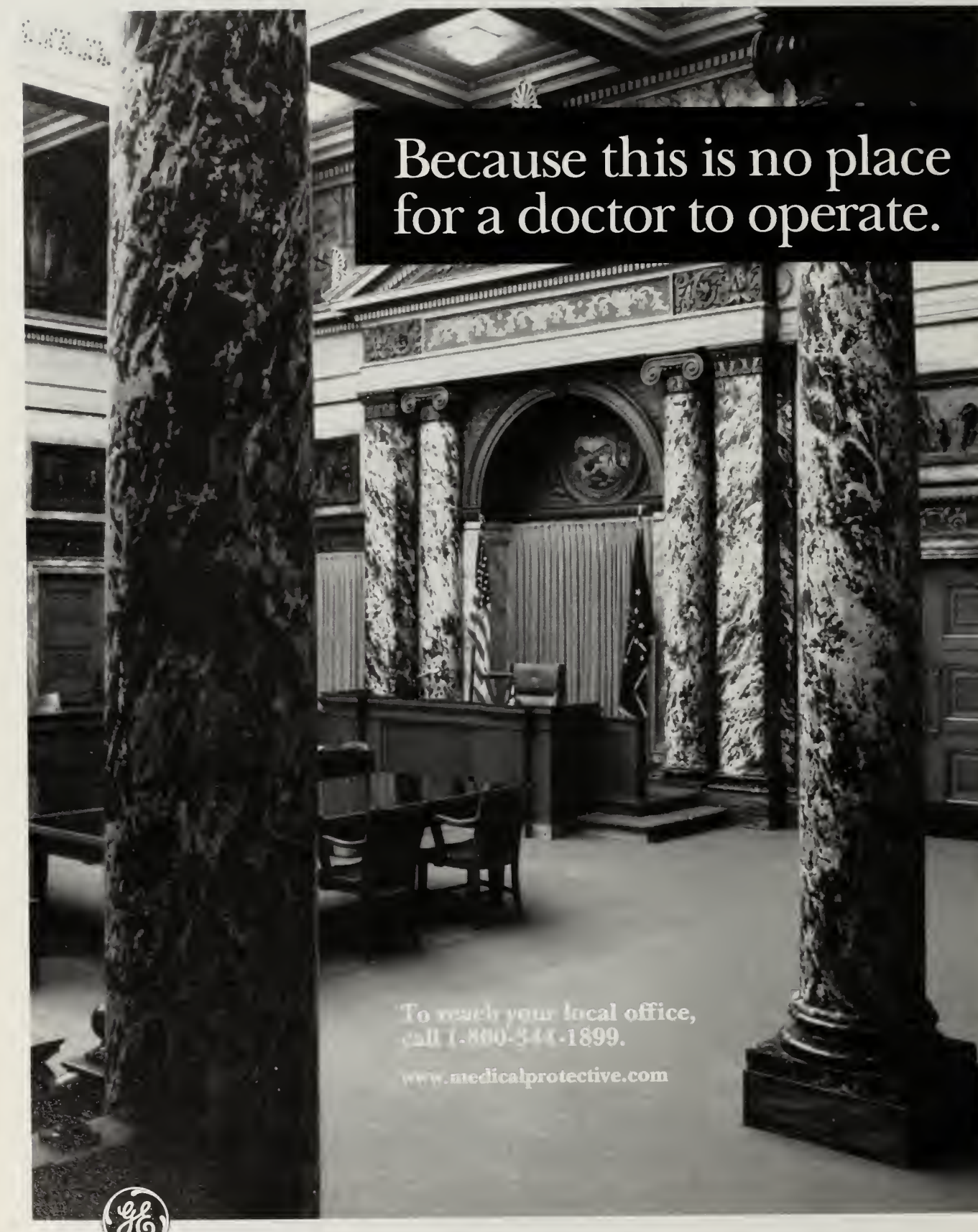
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KMA News Review

Below are synopses of news items that have appeared recently in various publications regarding issues of interest to Kentucky physicians.

- The average base salary for a medical director of an HMO is \$190,345, while the average base salary for a medical director of a non-profit HMO is \$179,951. The total amount of base salary, bonuses and incentives paid to medical directors went up some 5% last year. [*Managed Care Magazine*]
- HMOs suffered a combined \$490 million loss during 1998, with 56% of them reporting losses on their bottom-lines. These figures compare to \$768 million in losses during 1997, with 57% of HMOs reporting losses on their bottom-lines. [*Reuters*]
- Saying that health plans are shortchanging them and taking too long to pay, Florida physicians have filed suit against two HMOs, HIP Health Plan of Florida and United Healthcare of Florida. The number of complaints regarding late payments in the state led to the Department of Insurance auditing the state's health plans to check their compliance with prompt payment laws. [*St. Petersburg Times*]
- United HealthCare of New England is planning to launch a controversial program that will require its 35,000 Medicare HMO enrollees to use hospital-based physicians known as "hospitalists" for all inpatient care. United's medical director said, "[T]he physician community is a bit upset." [*Bureau of National Affairs, Health Law Reporter*]
- While capitation has not become as popular in healthcare as first predicted, it is resurging in a new form, targeting specialists instead of primary care physicians. Such capitation for specialists is sometimes called "contact capitation" which pays physicians based on the percentage of patients whose care they manage within their specialty. Each specialty works out a "cap pool," or a monthly allotment of funds. [*Modern Healthcare*]
- While some employers have rated the various health plans available to their employees, and have offered to pay a higher percentage of premiums for employees who choose higher rated plans, one HMO is now rating physician medical groups. PacifiCare of California distributed clinical and service quality data for medical groups in its network to many businesses, who have, in turn, distributed these ratings to employees. PacifiCare claims the data may have had an impact on consumer choice of medical groups, but medical groups claim they have not seen an impact. [*AMNews*]
- The number of drugs prescribed by nurse practitioners and physician assistants has risen dramatically in the past year because of the increased authority given to these groups. Nurse practitioners wrote 15 million prescriptions last year, up 66% from the previous year. Physician assistants wrote 12 million prescriptions, up 33%. [*FoxNews*]
- Pinched by soaring costs and prodded by employees who say they need more choices, a growing number of companies are handing over money for health care for employees to spend as they see fit. Other companies are threatening to get out of providing health care benefits altogether since such costs are expected to double over the next nine years. [*Seattle Times*]
- HMO Health Ohio became the last HMO to pull out of the Medicaid managed care program in the Cincinnati area. While some 45 states have tried to implement Medicaid managed care, many are running into difficulties including federal government bureaucracy, state mandates, and low payments. In Cincinnati this past year, the state cut payments to the participating HMOs by 15%. [*Washington Post*]



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AN ANALYSIS OF THE LATE EFFECTS OF RADIOTHERAPY IN PEDIATRIC CENTRAL NERVOUS SYSTEM TUMORS

David F. Butler, MD; B. Oliapuram Jose, MD; Kristie J. Paris, MD; William J. Spanos, Jr, MD;
Robert D. Lindberg, MD; L. Jane Goldsmith, PhD

Purpose—The purpose of this study is to assess the long term results of all pediatric patients diagnosed with central nervous system (CNS) tumors treated with external beam radiotherapy either primarily or postoperatively. **Materials**—Forty-seven pediatric patients with CNS tumors were treated between 1978 and 1989 with external beam radiotherapy to customized fields using cobalt 60, 4, 6, or 18 MV photons. Daily doses ranged from 1.5 to 2.0 Gray; total doses from 35 to 66 Gray. Ages ranged from one month to 18 years of age, with an average age of 8.2 years. Thirty-nine patients survived more than 12 months (range 36 to 178 months; median 62 months) and were included for analysis. Ten of 39 (25.6%) patients experienced Grade I to II complications and six patients had (15.7%) Grade III to IV complications for an overall incidence of 41%. The influence of field size, radiation dose, chemotherapy, age, and extent of surgical resection upon long-term complications were studied. **Conclusion**—Radiation therapy for pediatric CNS malignancies is associated with long-term complications. Significant long-term complications can be limited to an acceptable level of approximately 15%.

Therefore, in addition to the above parameters, quality of life and severity of complications must also be examined.

Treatment of pediatric brain tumors depends upon a multitude of factors including the age of the child at diagnosis, tumor type, tumor location, and extent of neurologic sequelae imposed by definitive treatment. By balancing these factors with the intent of maximizing benefit and minimizing harm, durable survivals have been achieved without imposing excessive neuropsychologic harm.

The incidence of pediatric central nervous system malignancies in the United States is 2.4 new cases per 100,000 children per year, resulting in 1200 new cases per year. Among these new cases, there is a multitude of histologies. The low incidence of pediatric brain tumors combined with the large number of tumor types has made multi-institutional trials necessary in order to achieve adequate patient numbers for large prospective randomized trials. The purpose of this paper is to retrospectively analyze the long term complications resulting from radiotherapy treatment of all pediatric central nervous system tumors at our institution from 1978 through 1988. Because of limited numbers of specific tumor types, all CNS tumors were grouped together for analysis. Extent of field, modality of treatment, age, and dose were analyzed as predictors of severity of late effects.

From St. Luke's Hospital, Radiation Oncology Center, Chesterfield, Missouri (Dr Butler); Department of Radiation Oncology, James Graham Brown Cancer Center, University of Louisville School of Medicine (Drs Jose, Paris, Spanos, Lindberg); and the Department of Information Technology, University of Louisville School of Medicine, Louisville, KY (Dr Goldsmith). Requests for reprints to Department of Radiation Oncology, Brown Cancer Center, University of Louisville, Louisville, KY 40292 (Dr Jose).

Brain tumors in children are the most common form of solid malignancy and rank second in incidence only to leukemias and lymphomas in childhood cancer. Survival of children with brain tumors depends greatly on histologic type, stage, and tumor location. Significant strides in the treatment of pediatric central nervous system malignancies have been made in the past 20 years. However, it is not just an improvement in overall or disease-free survival which merits analysis in the pediatric population. Because of their age, these patients are at risk for complications from their treatments for a much greater period of time than their adult counterparts.

METHODS AND MATERIALS

Forty-seven patients of 18 years of age and under, diagnosed with a central nervous system tumor, were treated with external beam radiotherapy at the University of Louisville from January 1978 through December 1988. Forty-five of the 47 patients had primary brain tumors, one had a spinal cord tumor, and the last patient had a primary brain tumor followed by a second primary tumor of the spinal cord. In addition to radiotherapy, many of the patients received surgery, chemotherapy, or both as components of their treatment. Methods of treatment varied on a case by case basis according to age, grade, tumor type, tumor location, resectability, and extent of disease.

Breakdown of tumor types is as follows: 17 astrocytomas; 6 ependymomas; 11 medulloblastomas; 4 dysgerminomas; 3 glioma; 2 craniopharyngiomas; 1 malignant teratoma; 1 pinealocytoma; 1 pituitary adenoma; and 1 retinoblastoma. Patients were treated with external beam radiotherapy to customized fields using Cobalt-60, 4, 6, or 18 MV photons. Daily doses ranged from 1.5 to 2.0 Gray, and total doses from 35 to 66 Gray. The age range of patients treated was from one month to 18 years of age, with an average age of 8.2 years.

Long term complications for the purpose of this paper were defined as those which occurred one year or later from the completion of radiotherapy. Thirty-nine patients were included for analysis. Eight patients were excluded as follows: one of the eight was lost to follow-up NED 4 months after treatment; seven patients survived less than 12 months. Survival for patients analyzed ranged from 36 to 178 months, with a median follow-up of 62 months.

Severity of long-term complications was graded according to the Radiation Therapy Oncology Group toxicity criteria. The neurologic toxicity scale evaluates mental status, motor paresis, cerebellar function, and seizures (Appendix 1). Behavioral, endocrine and height abnormalities were also graded according to RTOG toxicity criteria. If toxicity was not present prior to receiving radiotherapy, any subsequent

toxicities were attributed to radiotherapy regardless of the extent or duration of treatment by other subsequent treatment modalities. Prospective neuro-cognitive deficits were not studied in these patients.

RESULTS

Analysis of survival for the 39 patients is taken from the date of diagnosis. Mantle-Cox multivariate analysis was used to analyze the data according to age, radiation dose, chemotherapy, extent of radiotherapy fields, presence of preexisting toxicity, and severity of observed toxicity.

Overall survival at 178 months was 68% (Figure 1). Mean survival time was 130 months, with a range of 12 to 178 months. Median survival time was 53 months. Six patients had toxicity present prior to initiation of radiotherapy. When the 33 patients with no preexisting toxicity were analyzed, the overall survival was 62% at 178 months (Figure 2). The mean survival was 122 months (range from 12 to 178 months).

Of the 39 patients analyzed, 23 patients (59%) experienced no long-term toxicity as a result of their treatment; 16 (41%) experienced toxicity levels ranging from 1 to 4 based on the RTOG and CCSSG toxicity criteria. Six of the 16 (38%) with long-term toxicity due to treatment experienced their most severe level of toxicity prior to undergoing XRT. Two of the six had grade 4 toxicity; two grade 3; one grade 2; and one grade 1. Of the 10 patients with their most severe long-term complication attributed to XRT, 5 were grade 1; 3 were grade 2; and 2 were grade 3.

Survival with respect to age was examined in the overall population set, as well as in the subset of patients with toxicity due entirely to XRT. Several stratifications of age were analyzed: 10 years of age or less vs >10; 4 years of age or less vs >4; 2 years of age or less vs >2; and 2 years of age or less vs 2 to 10 vs >10. The stratification of 4 years of age or less versus greater than 4 years old in the overall population set tended towards statistical significance with a p-value of 0.1 (Figure 3).

Appendix 1. Neurologic Toxicity Criteria

	0	1	2	3	4
a) Mental status	No change	Transient alteration and/or minimal lethargy	Alteration substantially affecting function	Alteration substantially affecting function >50% of time	Comatose
b) Motor paresis	None	Mild or transient	Substantially affects function <50% decrement in baseline capabilities	Substantially affects function >50% decrement in baseline capabilities	Paralysis
c) Cerebellar function	No change	Mild or transient alteration	Substantially affects function <50% decrement in baseline capabilities	Substantially affects function >50% decrement in baseline capabilities	Confined to bed
d) Seizures	None	—	Transient or satisfactorily controlled by medical therapy	Seizure disorder not controlled by medical therapy	Status epilepticus
Bone Toxicity Criteria					
	None	Asymptomatic/No growth retardation Reduced bone density	Moderate pain or tenderness/Growth retardation/Irregular bone sclerosis	Severe pain or tenderness Complete arrest bone growth Dense bone sclerosis	Necrosis/spontaneous fracture
Mood Toxicity Criteria					
	No change	Mild anxiety or depression	Moderate anxiety or depression	Severe anxiety or depression	Suicidal ideation
Vision Toxicity Criteria					
	No change	—	—	Subtotal vision loss	Blindness

In all instances, the overall population set as well as the subset of patients without toxicity prior to XRT were analyzed. A scattergram analysis comparing dose to age showed a statistically significant correlate with a p-value of .02 (Figure 4). The implication of the above is that higher doses of radiotherapy were administered as age increased (a finding not unexpected based on currently accepted treatment guidelines).

DISCUSSION

Radiotherapeutic treatment-induced sequelae for children with primary brain tumors includes diminished endocrine function, altered intellectual and social behavior, neurologic dysfunction, and secondary neoplasms.¹⁻¹² Of the 16 patients with complications in this analysis,

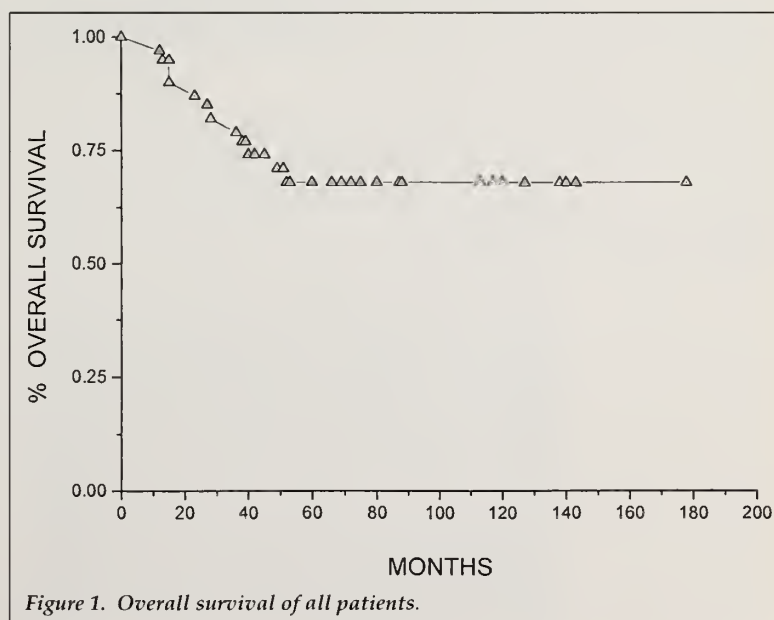


Figure 1. Overall survival of all patients.

AN ANALYSIS OF THE LATE EFFECTS OF RADIOTHERAPY IN PEDIATRIC CENTRAL NERVOUS SYSTEM TUMORS

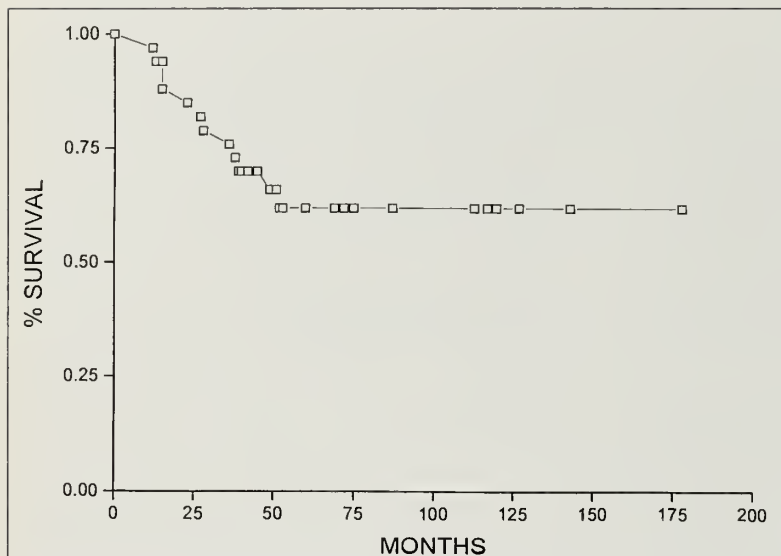


Figure 2. Overall survival of patients without pre-existing toxicity.

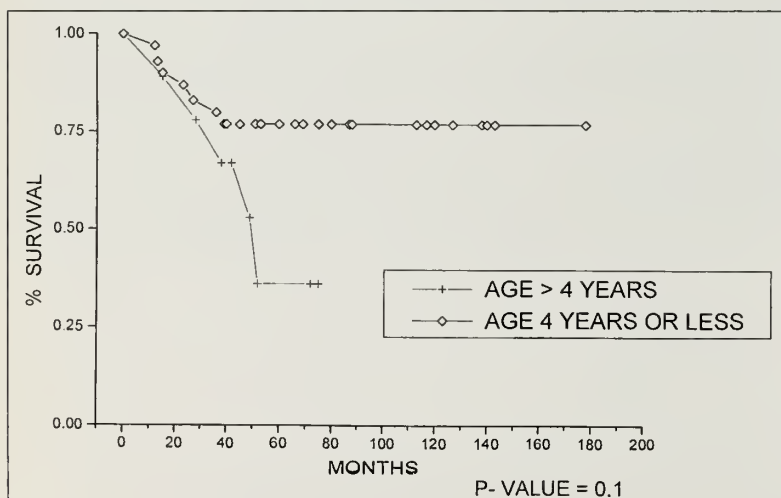


Figure 3. Survival by age grouping.

examples of all of these sequelae were recognized to some degree in our patient population based upon follow-up records and reports from parents and referral physicians. Of the patients who experienced toxicities from treatment received prior to radiotherapy, all six had neurologic toxicity to some degree. Among these six, there was also one behavioral, one endocrine, and one bone/stature toxicity recorded. Two patients had grade 4 toxicity within this

grouping. One of these two had a history of tuberous sclerosis which was the likely cause of the patient's symptomatology. This was attributed to pre-XRT toxicity because of the unclear time relationship between the onset of symptomatology and when surgical treatment occurred. The other patient experienced a spinal recurrence which required surgery prior to post-operative XRT. All deficits were present prior to radiotherapy (Table 1).

Of the 10 patients with their greatest toxicity attributable to XRT, there were 6 incidences of neurologic, 3 bone/stature, 2 endocrine, and 2 behavioral toxicities. Some patients experienced toxicity in more than one category.

Endocrine dysfunction was noted in three patients out of the 39 analyzed in this study, resulting in an incidence of 7.5%. If the patients with altered bone growth are included in this subset of patients (presumably due to decreased levels of growth hormone), the incidence increases to 6/39 (15%). Shalet et al reported a 50% incidence of growth hormone deficiency in 14 children treated with XRT and chemotherapy for primary brain tumors, and a 45% incidence in patients treated with radiation alone.^{2,3} Our study revealed a much lower incidence of clinical dysfunction; growth hormone levels were not measured in our patients. In another study reported by Shalet et al,⁴ only 25% of patients treated were short of stature, and some patients with growth hormone deficiency actually achieved normal height parameters. Other reports in the literature show a 35% incidence of short stature in pediatric patients treated with radiation for brain tumors,⁵ while another series demonstrated that most children with stunted growth were irradiated between the ages of 6 and 10, and that doses of less than 30 Gray to the pituitary rarely resulted in growth abnormalities.⁶ Fifty percent of children receiving >30 Gray demonstrated stunted growth.⁶

Three of the 16 patients in our study with toxicity demonstrated behavioral abnormalities attributed to treatment of their disease. One patient had mood swings, one patient demonstrated a childish affect inappropriate for age, and the other child had decreased attention in

high school. Overall, this represents 3/39 (7.5%) of treated patients that exhibited changes in behavior which deviated from the norm. The series reported by Danoff et al¹ revealed behavioral disorders in 39% of their treated patients, as compared with Bloom who reported a 25% incidence.⁷ This is in marked contrast to Hirsches' series with an incidence of greater than 90% in medulloblastoma patients. One explanation for the wide variance in reported results might be the heterogeneity of tumor types, location, and treatment modalities utilized. In a report by Cavazutti et al,⁸ patients with craniopharyngioma treated by subfrontal excision demonstrated a substantially higher rate of unemployment, educational difficulties, and behavioral problems as compared to patients treated with primary radiation therapy. In these studies, IQ and memory were not affected by treatment. However, the surgically treated patients demonstrated a uniformly poor performance in sorting tests which correlates with a frontal lobe dysfunction syndrome. In these cases, both treatment modality and location of the primary influenced overall behavioral toxicities.

Of the 16 patients with toxicity in our study, 13 exhibited neurologic toxicity (excluding patients with short stature or endocrine abnormalities alone). Thus, 80% of the recorded toxicities were neurologic, which accounts for a 33% incidence in the patient population overall. Grade 3 and 4 toxicities accounted for 4 of the 6 patients with greatest toxicities present prior to XRT, and 2 of the 10 patients with greatest toxicity attributed to XRT. Therefore, significant neurologic toxicities were manifest in 6 of 39 patients for an overall incidence of 15.4%. This is consistent with the data reported by Danoff et al¹ which showed an 11% incidence of severe neurologic toxicities, and Bloom et al with an incidence of 18%.⁷

Second malignancies occurred in one of the 39 patients in our series, for an overall incidence of 2.6%. This patient developed a spinal ependymoma after being treated for a supratentorial astrocytoma, and was one of the two patients with a grade 4 long-term complication.

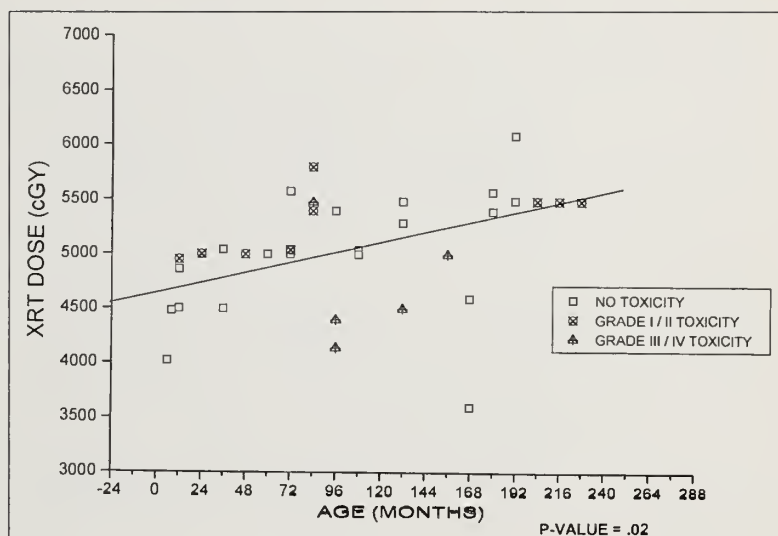


Figure 4. Scattergram showing toxicity according to total dose and patient age.

Our incidence of second neoplasms is consistent with reports from other series which observed an incidence in the range of 1 to 5%.^{1,9,10} Haselow reported the lower of these two incidences for radiation-induced second malignancies over a 14-year man follow-up. Tefft's 5% incidence is for both malignant and benign second neoplasms in children who survived greater than two years after receiving doses greater than 10 Gray.¹⁰

CONCLUSION

Improved survival in pediatric patients with CNS tumors appears to be associated with greater levels of toxicity. When dealing with pediatric populations, long term complications must be kept in mind in order to achieve higher cure rates while minimizing disabilities due to treatment. Based on past and ongoing protocol studies, tissue populations appear to be sufficiently defined to attain this goal of allowing patients to function with minimal disability after treatment.

Excluding patients with short stature or endocrine abnormalities alone, neurologic toxicity is the primary manifestation of late complications in patients irradiated to the CNS.

AN ANALYSIS OF THE LATE EFFECTS OF RADIOTHERAPY IN PEDIATRIC CENTRAL NERVOUS SYSTEM TUMORS

Table 1. Pediatric Complications

Pt. #	Sex	Age	Diagnosis	Brain Subsite	Toxicity Before XRT			Grade Toxicity	Toxicity
					Surgery	XRT Dose/FX			
1	F	7	Ependymoma	Frontal	Gross Debulk	54/30		1	Short Stature Resolved; Mild mood swings; mild L-sided weakness
2	M	7	Medulloblastoma	Cerebellum	Partial Resection	54.8/30		3	Encephalopathy from chemo prior to RT; Seizure due to surgery
3	M	11	Astrocytoma	Ventricles/ Mid-Brain	Partial Resection	45/22		4	Spinal recurrence; scoliosis; Paraplegia, bowel/bladder incontinence after surgery
4	F	8	Astrocytoma	Sellar	Complete Resection	41.4/23		3	2nd cancer; spinal ependymoma; Paraparesis 2 cancer; urinary/bowel incontinence & hypopituitarism 2 surgery; scoliosis
5	F	6	Astrocytoma	Cerebellum	Partial Resection	50.4/28		2	R-Sided Palsy
6	F	14	Astrocytoma	Mid-Brain	Partial Resection	66/33		4	Brain atrophy & uncontrolled seizure disorder prior to XRT; history of tubular sclerosis
Toxicity After XRT									
7	M	4	Ependymoma	Ventricles	Partial Resection	50/25		2	Seizure D/O after XRT; no Rx required
8	F	18	Dysgerminoma	Pineal Region	Partial Resection	55/30		1	Atrophic changes retina after XRT; no vision loss mild vertical nystagmus after surgery
9	F	13	Dysgerminoma	Sellar Region	Biopsy Only	50/25		3	Diabetes insipidus after surgery; Pain hypopituitarism & seizures after XRT
10	M	7	Glioma	Brain Stem	Biopsy Only	58/29		2	Childish affect; seizure D/O
11	F	17	Pinealocytoma	Pineal Region	Partial Resection	55/30		1	Decreased attention high school; Mild adductor muscle weakness before XRT
12	M	8	Craniopharyngioma	Sellar Region	Complete Resection	44/22		3	Short stature; permanent
13	M	1	Astrocytoma	Cerebellum	Partial Resection	49.5/33		2	Short stature; decreased, but no absent bone growth
14	F	4	Astrocytoma	Brain Stem	Biopsy Only	50/28		2	Scoliosis; seizure D/O
15	M	18	Astrocytoma	Temporal Lobe	Partial Resection	55/30		2	Flashing light; seizure D/O
16	F	2	Astrocytoma	Mid-Brain	Partial Resection	50/25		1	Precocious puberty

Grade 3 or 4 toxicities manifest in approximately 15% of patients and cause significant disabilities in the population treated. While this incidence is within an acceptable range when compared to the literature, other methods must be investigated to further decrease this incidence. Behavioral abnormalities, short stature, and altered bone growth each occur in less than 10% of patients treated and appear to allow the majority of patients to function with minimal disabilities. Second primary malignancies in

children after CNS irradiation has an incidence of less than 2% and is comparable to incidences in children with tumors not treated with XRT.

In most instances, it appears that the advantages of radiotherapy in these settings outweighs the risks of potential late effects. Further randomized prospective studies are needed in order to refine both radiotherapy and other modalities used in the treatment of these patients in order to minimize treatment-related sequelae.

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PEDIATRIC DIABETES MANAGEMENT IN APPALACHIAN KENTUCKY: ADHERENCE OF PRIMARY CARE PHYSICIANS TO ADA GUIDELINES

Heidi M. Schoepflin, BBA; Kathryn M. Thrailkill, MD

Objective—The prevalence of diabetes mellitus in Eastern Kentucky is estimated at nearly three times the national average. Unfortunately, Eastern Kentucky's Appalachian region also faces poverty levels of at least twice the national average, a factor which could adversely affect the ability of families of pediatric diabetic patients in this region to access remote pediatric diabetes subspecialty programs. Therefore, the objective of this study was to survey current pediatric diabetes practice standards among Eastern Kentucky's primary care physicians and compare them to guidelines for diabetes management set forth by the American Diabetes Association (ADA).

Research Design and Methods—Surveys were sent to 402 primary care physicians practicing in 25 Kentucky counties designated as rural by the Appalachian Regional Commission (ARC). Information was sought to determine the frequency of diabetes-related office visits, recommendations for glucose monitoring, typically prescribed insulin regimens, monitoring of diabetes-related complications, and the availability of diabetes-care support staff.

Results—It was found that the majority of primary care physicians in this region met ADA guidelines for frequent follow-up evaluation of diabetes. However, they generally did not meet ADA guidelines for intensive management of diabetes by typically recommending self blood-glucose monitoring ≤ 2 times/day, the use of ≤ 2 insulin injections/day to maintain glycemic control, and inconsistent screening for the occurrence of diabetes-related complications.

Conclusions—These results support the need for further medical education of primary care physicians in Eastern Kentucky in the management of children with Type 1 diabetes.

ADA—American Diabetes Association; ARC—Appalachian Regional Commission; CSII—Continuous subcutaneous insulin infusion (ie, insulin pump); DCCT—Diabetes Control and Complication Trial; MIR—Multiple injections of regular insulin; MNT—Medical nutrition therapy; SBGM—Self blood glucose monitoring

The Diabetes Control and Complications Trial (DCCT) was definitive in demonstrating that long-term maintenance of "near-normal" blood glucose control in patients with Type 1 diabetes mellitus could impart as much as a 60% to 70% reduction in the incidence of diabetic microvascular complications, including diabetic retinopathy, nephropathy, and neuropathy.¹ As a result of these striking findings, the medical management of Type 1 DM is now directed both at preventing the acute complications of hypoglycemia or hyperglycemia and at preventing or reducing the risk of long-term morbidity by maintaining near-normal blood glucose control in each patient.

In a pediatric diabetes subspecialty clinic, these goals are generally accomplished through the use of a multidisciplinary team approach to diabetes care, implementing a strategy of *intensive diabetes management*.¹ By utilizing a team which includes endocrinologists, diabetes nurse educators, diabetes dietitians, mental health professionals, and social workers, multidisciplinary team management is a more efficient and effective means of providing the multidimensional health care necessary for the diabetic patient. Moreover, the DCCT demonstrated that frequent contact with such a diabetes medical team is a critical factor in implementing this therapeutic approach.¹ Oftentimes, however, a comprehensive diabetes care team is only available in association with a tertiary care facility, potentially excluding those patients living in remote areas who are not capable of reaching an advanced medical facility for frequent evaluation.² In fact, nationally, primary care physicians manage most diabetes-related office visits,

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while visits to diabetologists and endocrinologists comprise only 2.5% of all diabetes-related evaluations.³ Such realities of health care delivery underscore the importance of assessing the awareness of intensive diabetes management practices among non-specialists.

A recent study by Zoorab & Mainous⁴ evaluating the practice patterns of rural family physicians in Brown County, Ohio, demonstrated that ADA standards for medical care of Type 2 diabetes were not routinely met in this setting. Additional studies have found that elderly patients with diabetes,⁵ and patients in urban settings⁶ do not receive optimal diabetic management. Similarly, a study by Tuttleman et al⁷ found that in 1993, across the country, practice patterns of non-specialist physicians indicated a lack of awareness and/or acceptance of criteria for intensive treatment of Type 1 diabetes (ie, HbA_{1c} goals, importance of self blood glucose monitoring (SBGM) and use of multiple injections).

In Eastern Kentucky, the incidence of Type 1 DM is particularly high, estimated in 1993 at three times the national average.^{3,8} According to a recent report by the American Medical Association, there is a shortage of 2,091 physicians in Kentucky's Appalachian region. This correlates with one physician per 1,184 persons.⁹ Maintaining an average poverty rate of 30%, an unemployment rate of 12%, and an average income of \$8,017, many counties of Kentucky's Eastern region have been designated as distressed by the Appalachian Regional Commission¹⁰ (Figure 1). It is also important to consider that this is a region where roughly 40% of the population is under the age of 25, suggesting that a relatively greater proportion of Kentucky's pediatric diabetes patients may reside in this region. Therefore, evaluation of current pediatric diabetes care in this underserved and rural region is particularly important, due to the relatively high incidence of disease, yet low availability of medical specialty care.¹¹ The purpose of the present study, therefore, was to examine the consistency between current pediatric diabetes practice standards among private practitioners in

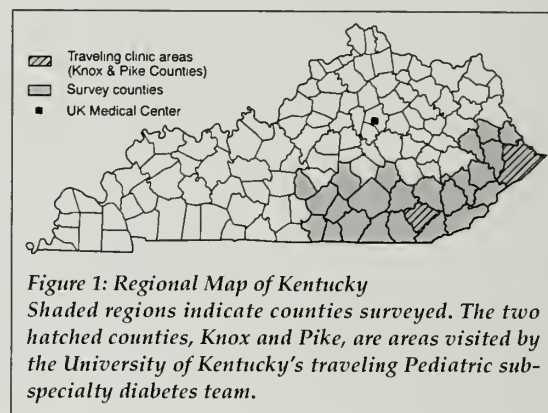


Figure 1: Regional Map of Kentucky
Shaded regions indicate counties surveyed. The two hatched counties, Knox and Pike, are areas visited by the University of Kentucky's traveling Pediatric subspecialty diabetes team.

Eastern Kentucky and the ADA's guidelines for diabetes management, and to assess the possible need for further education about pediatric diabetes management among rural practitioners in Appalachian Kentucky.

RESEARCH DESIGN AND METHODS

To determine the standard of care for the management of pediatric Type 1 Diabetes Mellitus patients in rural Appalachia, a questionnaire was sent to physicians covering 25 counties in Kentucky's Appalachia region. (Adair, Bell, Casey, Clay, Clinton, Cumberland, Floyd, Green, Harlan, Johnson, Knott, Knox, Laurel, Leslie, Letcher, Magoffin, Martin, McCreary, Perry, Pike, Pulaski, Rockcastle, Russell, Whitley, and Wayne counties.) Physicians who were likely candidates for treating children and adolescents with Type 1 Diabetes Mellitus (DM) were contacted and included those physicians practicing in internal medicine, family practice, and pediatrics. All physicians were identified through the August 1996 edition of the *Kentucky Medical Directory* by county of practice.

The purpose of the questionnaire was to assess current practice methods among non-specialist rural practitioners in the treatment of insulin dependent diabetes in the pediatric patient. Questions were designed to determine the frequency of diabetes-related office visits, recommendations for glucose monitoring and assessment of glycemic control, insulin pre-

scribing practices, use of ancillary screening tests, and the availability of office support staff. Physicians were also queried as to their interest in participating in locally accessible Continuing Medical Education (CME) programs on pediatric diabetes management, as well as their interest in referring patients to a local clinic, staffed by a "traveling" Pediatric Subspecialty Diabetes Team.

Surveys were mailed to 402 physicians in April 1997. All surveys received through September of 1997 were included in this study.

RESULTS

One hundred twenty-four completed surveys were returned, which represented a 31% response rate. Of those 124 responses, 32 physicians were treating a total of 203 pediatric patients with Type 1 DM. Six surveys were returned unopened. Based on a disease incidence of 1.7 cases/1000 population for children under 18 years of age,³ it can be estimated that the incidence of type 1 DM in the 48 counties of Appalachian Kentucky (Kentucky Health Districts 8-14) totals 446 children. Consequently, survey responses are estimated to represent ~46% of children with Type 1 DM in Eastern Kentucky.

For the purpose of analyses, primary care physicians indicating that they were the principal provider of diabetes care to their patients were designated as non-referring physicians (NRP; $n=9$), while those who refer their pediatric Type 1 DM patients to an endocrinologist were designated as referring physicians (RP; $n=23$). Survey responses among these groups were then compared with current ADA guidelines for the management of Type 1 DM in childhood.¹²

Responding physicians indicated that on average they treated five pediatric Type 1 DM patients per practice. Of those physicians whose practice included pediatric Type 1 DM patients, 28% were the primary source of care for these patients, while 72% always or frequently refer these patients to an endocrinologist. However, non-referring physicians cared for 38% of the

203 identified patients. The reasons for not referring pediatric diabetic patients to a subspecialist varied: Sixty-six percent of those who did not refer their patients to a diabetes specialist indicated that referral was not necessary or that the patient did not desire a referral, whereas 33% cited the lack of a locally accessible endocrinologist as the deterrent to referral.

Physician profiles demonstrated that the majority (78%) of non-referring physicians completed their medical training after 1980, while only 48% of referring physicians received their medical degree in 1980 or later. The average age among both groups of physicians was quite similar, with the mean age of 45 years for the non-referring practitioner, and 48 years for the referring physician. Physicians in the non-referring group included family practitioners (67%), internists (22%) and pediatricians (11%). In contrast, 61% of referring physicians practiced family medicine, while the remaining 39% were pediatricians. Internists were not represented among the referring physicians. Fifty-nine percent of physicians surveyed were solo practitioners, while 38% were in a group practice. Out of the 25 counties surveyed, the majority of respondents practice in Pike and Perry counties.

Current ADA guidelines recommend follow-up of patients with Type 1 DM once every 3 months whenever glycemic goals are not being met.¹² When asked about the frequency of patient visits among non-referring physicians, 61% estimated that they see their pediatric diabetic patients every month, whereas 28% stated that pediatric diabetic patients were seen every 3 months, and 11% indicated that patients should be seen only when there was concern. It was not distinguished whether the visits were solely for the follow-up of diabetes, or if they were for the treatment of other illnesses. These figures contrast with that of referring physicians, where 20% of patients referred were seen monthly, while 54% were seen every 3 months. The remaining 26% of patients were seen every 4 months, 6 months, or yearly.

The types of insulin regimens utilized by both non-referring and referring physicians were comparable. The majority of physicians

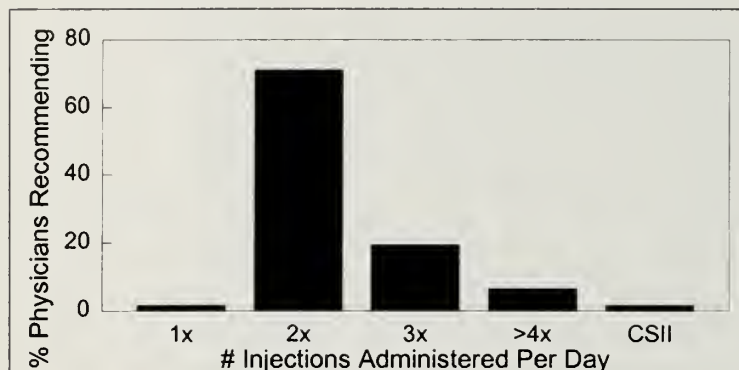


Figure 2: Frequency of Insulin Injections among All Physicians Surveyed
Physician recommendations for the frequency of insulin injections are shown, as a percentage of all physicians surveyed. Physicians were asked to indicate whether patients in their practice typically are prescribed 1, 2, 3, or ≥ 4 insulin injections daily, or continuous subcutaneous insulin infusion therapy (CSII).

in both groups prescribed a split mix of NPH/Regular or NPH/multiple injections of regular (MIR) and roughly all of the patients in both groups were receiving at least two insulin injections per day (Figure 2). Use of more intensive insulin therapy, either 3-4 injections per day or continuous subcutaneous insulin infusion (CSII) was less frequent among all physicians surveyed (23%). Among physicians surveyed, there was little or no use of long-acting (ie, Ultralente) insulin or very rapid-acting insulin (ie, insulin lispro-brand Humalog®).

The ADA recommends that a patient measure fingerstick blood glucose levels three or

more times per day (typically before meals and before bedtime).¹² Among all primary care physicians surveyed, only 42% recommended that home blood glucose monitoring be performed three or more times a day (see Figure 3). The remaining 51% advised their patients to check blood glucose levels two or fewer times per day. Among both groups, 47% of physicians stated that a glycated hemoglobin or HbA1c level, indicators of average glycemic control during the preceding 2-3 months, should be checked every 3 months. This contrasts with 53% of physicians who measured HbA1c levels in their patients every 6 months to a year, or when concerned about the glycemic status of their patients. Taken together, less than half of physicians surveyed were in compliance with ADA guidelines for routine home and/or office assessment of glycemic control.

Among both non-referring and referring physicians, most instructed their patients to test for urinary ketones during episodes of hyperglycemia or illness, consistent with ADA recommendations.¹² However, over three times as many non-referring as referring physicians (33% vs 9%, respectively) never instruct their diabetic patients to test for ketonuria.

Regular screening of thyroid hormone levels was considered to be a routine test among the majority of physicians surveyed (NRP, 67%; RP, 74%, Table 1). This was in contrast to recommendations for periodic measurement of uri-

Table 1. Compliance with ADA Testing Requirements

Test	% Total Physicians In Compliance	% Non-Referring MDs In Compliance	% Referring MDs In Compliance	ADA Recommendations
Hemoglobin A 1 c	47%	43%	56%	Performed every 3 months
Ophthalmology Exam	91%	100%	87%	Performed annually**
Urinary Albumin Excretion	63%	100%	48%	Performed annually**
Thyroid	72%	67%	74%	Performed every 2 years
Lipid Panel	69%	67%	70%	Performed every 2 years***

*Administered in the frequency recommended by the American Diabetes Association

**See Table 2

***Based on practice recommendations

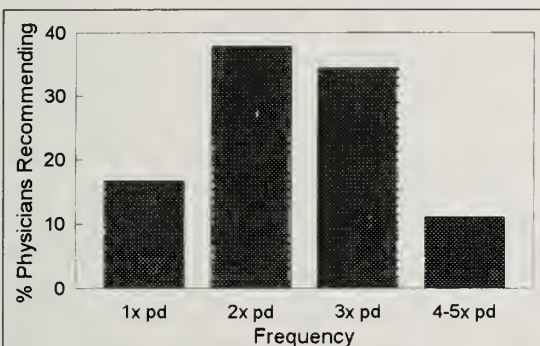


Figure 3: Frequency of Blood glucose Testing among All Physicians Surveyed

Physician recommendations for the frequency of self-blood glucose monitoring are shown, as a percentage of all physicians surveyed. Physicians were asked to indicate their recommendations for the number of SBGM tests per day (pd).

nary albumin excretion rates: All non-referring physicians considered this test to be routine, while only 48% of referring physicians indicated that measurement of urine albumin excretion rates was necessary in children with Type 1 DM. Nearly all non-referring as well as 87% of referring physicians responded that regular ophthalmology exams were necessary (Table 1). This is consistent with ADA recommendations that visual examinations be conducted yearly or as adapted for pediatric practices (Table 2).¹² Current ADA guidelines for assessment of serum lipid levels, available for adults but not children, recommend that an abnormal lipid value should be tested annually until improvement is noted, at which time lipid levels may be tested less frequently.¹² Sixty-six percent of physicians in both groups considered serum lipid profiles to be a necessary routine test in the pediatric patient with Type 1 DM.

Physicians were also surveyed about the extent of ancillary support available to their practice. Sixty-seven percent of non-referring physicians had at least one ancillary medical staff member (ie physician assistant, diabetes dietitian, diabetes nurse educator, LPN) to assist, whereas only 48% of those who refer pediatric Type 1 DM patients to a subspecialist retained such support. Of the non-referring

Table 2. ADA Recommendations for Patients with Type 1 DM for Pediatric Practitioners.

- I. Contact frequency
 - A. Daily for initiation of insulin or change in regimen
 - B. Weekly change in regimen
 - C. Routine diabetes visits
 1. Quarterly for patients who are not meeting goals
 2. Semiannually for other patients
- II. Medical history
 - A. Assess treatment regimen
 1. Frequency/severity of hypo-/hyperglycemia
 2. SMBG results
 3. Patient regimen adjustments
 4. Adherence problems
 5. Lifestyle changes
 6. Symptoms of complications
 7. Other medical illnesses
 8. Medications
 9. Psychosocial and school-related issues
- III. Physical examination
 - A. Physical examination annually
 - B. Dilated eye examination annually
 1. For patients ≥ 10 yrs. of age, beginning within 3-5 yrs after onset of DM
 - C. Every regular diabetes visit
 1. Weight
 2. Blood pressure
 3. Previous abnormalities on the physical exam
 4. Foot examination (adults)
- IV. Laboratory evaluation
 - A. GHb
 1. Quarterly if treatment changes or patient is not meeting goals
 2. Twice per year if stable
 - B. Fasting plasma glucose (optional)
 - C. Fasting lipid profile annually (if indicated)
 - D. Urinalysis for protein annually
 1. Beginning at puberty, after 5 yrs from onset of DM
 - E. Microalbumin measurement annually (see D)
- V. Review of management plan
 - A. Evaluate each visit
 1. Short and long-term goals
 2. Medications
 3. Glycemia
 4. Frequency/severity of hypoglycemia
 5. SMBG results
 6. Complications
 7. Control of dyslipidemia (if indicated)
 8. Blood pressure
 9. Weight
 10. MNT (with annual comprehensive nutritional assessment)
 11. Exercise regimen
 12. Adherence to self-management training
 13. Follow-up of referrals
 14. Psychosocial adjustment
 - B. Evaluate annually
 1. Knowledge of diabetes
 2. Self-management skills

Adapted from *Diabetes Care*, Vol 21, Supplement 1, January 1998.

physicians, 22% have a diabetes nurse educator on staff, while 44% employ a physician assistant (PA) or nurse practitioner (NP). Fifty-two percent of referring physicians responded that they had no office support whatsoever, only 9% had the assistance of a diabetes nurse educator, while 31% have the assistance of a PA or NP.

Almost all physicians stated that they were in favor of a traveling pediatric subspecialty clinic in their area. All non-referring physicians indicated an interest in attending a CME course designed to inform physicians of current pediatric diabetes practice guidelines. Likewise, most referring physicians (91%) expressed an interest in a locally accessible CME review of Type 1 DM management. Half of those not interested in CME review indicated that they had already received further education on this topic.

CONCLUSIONS

Our results indicate that the majority of non-referring physicians are meeting ADA guidelines (Table 2) for good management of diabetes through frequent office follow-up. Sixty-one percent saw their patients monthly, which is more frequently than the 3-month interval recommended by ADA guidelines and 28% recommend a quarterly evaluation. Unfortunately, 11% of non-referring doctors still recommend visits only when prompted by a medical concern. As the purpose for the visits was not stated, it is difficult to determine the exact reason for frequent office visitation. Since respondents are primary care physicians it is possible that many visits were for the treatment of unrelated illnesses. Over-monitoring or the treatment of diabetic complications cannot be ruled out as other reasons for overly frequent office visits.

All physicians were generally well informed about routine guidelines for insulin therapy. The type of insulin prescribed by both referring and non-referring physicians is consistent with that prescribed by pediatric endocrinologists; however, there was little or no use of insulin lispro among both NRP and

RP. Insulin lispro is an insulin analog with a more rapid onset of action and a shorter duration of action than human regular insulin. Therefore use of this product has been recommended for pre-meal dosing, to provide for insulin availability which more closely imitates endogenous patterns of insulin secretion following a meal. Potential advantages of therapy with insulin lispro include a decrease in postprandial glucose rise and a reduction in nocturnal hypoglycemia. Because lispro insulin may not be as widely used among diabetologists it is not unexpected that primary caregivers are less familiar with this form of insulin therapy in children. Infrequent usage of ultralente insulin mixtures was also apparent. Of note, however, among all physicians surveyed, the majority recommend therapy with two or fewer insulin injections per day. While similar care is periodically recommended by specialists, particularly for the management of the very youngest patients with Type 1 DM, goals of intensive diabetes management, as practiced by diabetes subspecialists, often mandate a multiple component insulin regimen consisting of three or more injections daily.

In contrast to the good compliance with practice guidelines regarding frequent evaluations and insulin regimens, the majority of primary care providers were generally not in compliance with guidelines for monitoring glycemic control in their patients. The majority of physicians surveyed recommend SBGM two or fewer times daily, though non-referring physicians were more likely than referring physicians to recommend more frequent SBGM. The frequency in which non-referring physicians test their patients' HbA1c was also disappointing. Recent clinical studies have indicated that in maintaining HbA1c levels within a defined range, the onset of retinopathy, nephropathy, and neuropathy are diminished significantly.¹³ Retinopathy and nephropathy are the two complications that correlate most readily with HbA1c levels. For example, it has been shown that among patients with a cumulative mean HbA1c over 10 years from the time of diagnosis of $\geq 10\%$, 43% developed retinopathy, while the

incidence of retinopathy was contained to only 10% of patients maintaining a HbA1c less than 8%. Similarly, comparing patients who maintain HbA1c values in the lowest quartile (HbA1c 4.7-7.0%) with those whose HbA1c values fall in the highest quartile (HbA1c 9.6-17.2%), the prevalence of microalbuminuria, an indicator of incipient nephropathy, increases from 12% to 36%. Since studies support that ideal HbA1c levels vary according to the patient's age, in general, HbA1c levels should be maintained at or below 7%.

These data suggest that areas in which primary care physicians appear to be generally deficient in diabetes information relate to the current practice of *intensive diabetes management*. Practices performed in an intensive type of management involve the use of multiple insulin injections, frequent SBGM (\geq four times per day), frequent assessment of HbA1c (\geq every 3 months), and periodic screening for concurrent autoimmune disorders and the onset of microvascular complications.¹ The overall low compliance among primary care physicians with this aspect of intensive diabetes management suggests the need for further education in this area, particularly since conflicting recommendations by primary care physicians and specialists will likely contribute to confusion and non-compliance by the patient.

The dynamics of managing a rural practice set it apart from standards set in urban areas. Healthcare delivery in rural areas is less specialized and focuses on the more extensive aspects of medicine. In addition, there is less likelihood that rural medicine will employ measures used in preventive medicine.¹⁴ These constraints and attitudes may affect the willingness of the generalist to adopt a stricter diabetes regimen for patients as a means in preventing long-term complications. Recent research investigating the applicability of the DCCT study to private practice showed that the ability to retain a diabetes management team as well as the financial resource requirements for such a team, contributes the most to deviations from the DCCT in the clinical setting.¹⁵ In fact, the amount of money spent per patient per year was four

times higher in the DCCT study than in clinical practice. Such financial constraints may make it impractical for the rural primary care physician to implement an intensive diabetes management strategy. In keeping with this hypothesis, 72% of physicians surveyed always or frequently referred their pediatric diabetic patients to an endocrinologist.

Limited local access to diabetes support personnel may also contribute to this trend. A recent study examined the effect of psychotherapy versus the exposure to a diabetes nurse educator (DNE) on diabetes management.¹⁶ It was found that good glycemic control was best attained when patients were exposed to a DNE on a continual basis. Similarly, a recent study conducted by the Jefferson County Health Department in Louisville, KY, concluded that patients who received instruction from a diabetes educator had lower HbA1c levels than those who did not receive intensive instruction.⁸ The role of the DNE in preparing a child with the necessary tools to establish a foundation for a lifetime of self-care is crucial to the patient's long-term health and well being. Studies by Bannister et al demonstrate that teaching young children with diabetes through play strategies develops a child's diabetes self-care habits, helping them to establish independence and strengthen their relationship with health care providers.¹⁷ Unfortunately, unless there is a significant patient population requiring a diabetes management team, it is unlikely to be cost effective for the typical primary care physician to retain such personnel.

To improve geographical access to specialized diabetes care, the Division of Pediatric Endocrinology and Metabolism at the University of Kentucky conducts traveling DM clinics, making trips every 3 months to Barbourville, KY (Knox Co) and Pikeville, KY (Pike Co). While the majority of physicians surveyed were from nearby Perry and Pike counties, 11% of responding physicians stated that they did not refer their pediatric diabetic patients because of a lack of available endocrinologists in their area. It is possible that family practitioners and internists are unaware of these local traveling

clinics; nevertheless, results from a recent study indicate that the presence of specialists in a rural area does not necessarily prevent primary care physicians from treating those conditions that have been historically treated by specialists.¹⁸

In addition to a perceived lack of available specialists, patient-related financial constraints may impact upon utilization of subspecialty diabetes care. Studies have shown that the out-of-pocket expenses are greater for families of children with DM than for families without a member with a chronic illness.¹⁹ Moreover, insurance-carrying lower income families are paying a greater percentage for their child's diabetes treatment than are medium income families that also possess an insurance plan. Lower income families may seek treatment by a primary care physician in lieu of a specialist, because the fees charged by primary care physicians may be less than those incurred through the services of a diabetes team.²⁰ Additional travel-related expenses may also be diminished by utilizing locally available medical care.

Interestingly, physicians who had graduated more recently from medical school appeared less willing to refer their patients to a subspecialty clinic. Due to the increasing influence of healthcare management organizations on specialty medical care, the role of the primary care physician has become more central in managing pediatric Type 1 DM patients. In some instances, the primary care physician must also serve as the gatekeeper whose objective it is to reduce the number of unnecessary medical visits to specialists.^{21,22} Consistent with this expectation, a recent study indicated that more than 90% of all adult diabetes follow-up visits are done by non-endocrine specialists.⁷

Ninety-one percent of all physicians surveyed were supportive of a traveling clinic in their area. One half of those physicians not in support of a traveling subspecialty clinic expressed an increased interest in pediatric diabetic patients and had already received further education on the topic. A recent study by Gleeson et al suggests that rural physicians are more willing to treat patients with HIV if provided with opportunities for further education

about HIV, as well as permanent access to a subspecialist.²³ Thus, continuing medical education in the care of the child with Type 1 DM might enable non-referring rural physicians to become more knowledgeable in the area of pediatric diabetes, while also allowing those who refer to better monitor their patients even though they are not the primary caregiver of diabetes management.

While ultimately the tight control of blood glucose levels rests in the hands of the patient, maintaining a close relationship with the physician is an important determinant of patient compliance.²⁵ Therefore, recognizing the various difficulties which may confront the rural primary care physician in caring for the child or adolescent with Type 1 DM is essential to developing strategies to deliver adequate health care to the rural diabetic population.

ACKNOWLEDGMENTS: The authors gratefully acknowledge critical reviews of this manuscript by Drs. John Fowlkes, W. Jackson Smith and Charlton Mabry. The cartographic work done by Dick Gilbreath is also appreciated. Work for this project was funded through a grant from the Appalachian Regional Commission (KY-12732-I-302).

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HARRY W. CARLOSS, MD

KMA PRESIDENT 1999-2000

... When geese fly, they fly in a V-formation with the lead goose creating a drafting effect, thereby increasing the lift of the other geese and enabling them to fly more easily . . .

As the members of the 1998 House of Delegates settled into their chairs following a standing ovation to welcome him, newly announced KMA President-Elect, Harry W. Carloss, MD, presented an attention-getting, thought-provoking vignette of team support and shared leadership. His comments were drawn from his love of the outdoors, adventure, and lessons from nature that are as old as time.

... When he gets tired he just drops back in the line and someone else comes forward and takes his place. . . . Just as there is no one leader of the flock of geese, there is no one leader of the KMA . . .

"It's not the President's job to be king or establish policy or directions," he says. The House directs the leadership of KMA—the direction to take and the issues to tackle. Currently those issues are well outlined in 'Future Search,' as initiated by Ken Peters. This is a team effort—the Kentucky Medical Association is an all member effort. The President simply articulates the position of the House of Delegates, the Board of Trustees, and the members of KMA." Dr Carloss has supreme self-confidence, but he doesn't enjoy talking about himself. Personal references are brief and somewhat self-effacing. "I'm just a spokesperson carrying forth the messages of the organization—a temporary spokesperson."

He is a regular guy, who introduces himself simply as "Harry Carloss." Titles, degrees, pretensions are not important—he's just Harry. He is approachable. He can be affable. He has wry humor. He is his own man, with a center, a comfortable reserve—sometimes mistaken as aloofness. Much of his appeal is owed to his outspokenness, which is tempered by a casual, colloquial style. He speaks slowly and deliberately, carefully measuring each word, but *he is* going to say what he totally believes.

HIS BACKGROUND

Born in Lexington, Kentucky, Carloss earned a bachelor's degree from the University of Kentucky, a medical degree from the University of Louisville School of Medicine, and then ventured across country

to the highly regarded Scripps Clinic and Research Foundation for advanced training.

His decision to become a physician was evolutionary, as was his choice of hematology/oncology. He speaks candidly, "I'm not sure when I decided I wanted to become a physician. I know I became serious about it when I was a junior in college. Prior to that I hadn't been serious about much in my life! But it is a decision I have never regretted.

"While in UofL medical school two new faculty recruits, both hematologists, ignited my interest and encouraged me to become a hematologist," he adds. "The first few years of my hematology training were at Scripps Clinic with a very important mentor, one of the fathers of hematology, Dr William H. Crosby."

This kindly, impressive physician proved to be an inspiration for the young resident. "One event left a lasting impression on me," he reminisces. "Dr Crosby was treating a patient with acute leukemia, a physician who had family members whose beliefs prevented medical intervention. He needed and wanted transfusions, but he didn't want anyone to know. Dr Crosby bought the blood out of his own pocket and gave the transfusions in the middle of the night so no family members would know. That was typical of his caring for all patients, regardless of their circumstances.

"My training years presented a dichotomy of people," he continues. "The Scripps Clinic and Research Foundation took care of the wealthiest people from throughout the world and money was no object. But every Wednesday Dr Crosby and I served at a charity clinic in El Centro, California, where no one could pay. But there was no difference in the care Dr Crosby gave those people—his care was the same for all patients, Monday through Friday, whether the El Centro Clinic patient or the owner of a large corporation."

One of life's pivotal moments occurred for Harry Carloss when Dr Crosby retired and was replaced with Dr Ernest Beutler, who edited the textbook on hematology. "I was planning to be a research doctor," he recalls. "But during one lecture, I was half asleep as I looked at three chalkboards full of something like hydroxy chicken wire, an illustration about biochemists drawing up the chemical structures of things as they changed in passing through the red cell membrane. In the middle of this lecture, Dr Beutler rose from the back of the room, approached the board, erased one of the compounds, and rewrote it! It dawned on me that I was competing with people with much different

backgrounds, and what I really wanted to do was take care of patients. I amended my career to become a people physician rather than a laboratory physician."

The small town of Paducah was the fortunate recipient of this "people physician," with his compassion and caring. His settling there must have been destiny. He explains, "While living in California, my wife and I had one child, and we had been told we could not have other children. We wanted that child to grow up in the best possible atmosphere, so we began looking at small towns throughout the United States. Paducah had been recruiting me because they did not have a hematologist/oncologist at that time. As it turned out, we got a better deal to go to Paducah than any other place! We had no ties there at all."

THE PROFESSION

The issues confronting medicine are complex and will affect physicians and their patients well into the 21st century. KMA President Carloss enters the debate with a firm grounding in reality, with a great deal of wisdom and expertise, and as a worthy advocate for medicine and for patients. He will not forego his role as *the caregiver* and is adamant in bringing a positive outlook to his work and the profession. He'll tell you that the true excitement of medicine lies in treating patients and getting to know them and their families on a daily basis. His oncology practice has a way of putting in perspective medicine's often stressful minutiae.

"My daughter is in medical school," he says, "and I'm really distressed by physician friends who comment, 'Why would you support your child to go to medical school knowing what you know?' These comments elicit my sympathy, because they missed the point. All through medical training, the most important thing to me wasn't dealing with the business pressures of a physician—it was the interesting case, the challenging clinical puzzle, the gratitude of the patient and family. In what other profession could you possibly have so many people be so grateful to you for doing what you love everyday? There is no greater reward than the 'thank yous.'" The compassion of his words is profound as he adds, "Being an oncologist, many of the thank yous come from patients who are unsuccessfully treated, from their families and relatives who remain after the patients have succumbed to their illness."

Dr Carloss views his leadership roles within organized medicine as fulfillment of his basic responsibility as a physician, which "encompasses more than just practicing hematology, oncology, and internal medicine. I must care for my patients in the legislative arena and in matters of public policy," he adds. "Standing alone, I cannot do this. Standing together, like the motto of the Commonwealth, 'United We Stand, Divided We Fall,' we can protect our patients,

preserve our profession, and support those who are behind us on the difficult path to becoming physicians. Interface with our peers and organized medicine provides an excellent place to accomplish this. These should be the top priorities of KMA and the top priorities of every physician."

The image of the profession as a whole needs work. It's a challenge to maintain a good standing with the public, but if it's in the public interest, then it should be in the profession's interest. The profession is beleaguered by many factors, and physicians must be visible, be out there presenting a positive view of their profession. Dr Carloss views this as a priority.

"An interesting survey ranked professions by lay persons as to what their usefulness and desirability in society was," he says. "The survey evaluated *your doctor* and *all doctors*. Everyone ranked *their doctor* very high but ranked *all doctors* somewhat far down the list. In the process of carrying out the desires of the House and KMA members, I hope we can rebuild the public's trust of the profession, convince people that *all doctors* are more like *their doctors*, and resonate some of the common concerns we have for the health and safety of all people of the Commonwealth."

ORGANIZED MEDICINE

It takes vision and enthusiasm to keep medicine's effort in the forefront, and Dr Carloss is not willing to accept what comes along. He anticipates change and attempts to influence the direction of that change. In making his opinion known, he does not complain but offers constructive insight and alternatives. He credits his parents for this. "When I was growing up, I was allowed to complain about almost anything. But in order to complain and not be reprimanded for it, I had to have an alternative way which I thought was better or some constructive solution."

His political motivation began in medical school. "My first medical office was as Chief Resident of Medicine at the University of Louisville. Later, I was Chief Hematology Fellow and Chief of all Clinical Fellows at the Scripps Clinic and Research Foundation." He never aspired to leadership, "it was a natural evolution and sequence of circumstances or events," he says. His initiation into KMA came when then President Wally Montgomery appointed him to the Committee to Investigate Changing Trends in Medicine. His stature grew with KMA as he went on to serve on other committees, followed by several years as First District Trustee in extreme western Kentucky, Board Chair, Vice-President, and President-Elect. Somewhere in between, Carloss served as Kentucky Governor of the American College of Physicians.

He is an exemplary model of his own admonition—"Get involved now in the activities of KMA and in the political process, and stay involved!"



Dr Carlross and his wife Barbara were surrounded by their three children as they celebrated his inauguration as 1999-2000 KMA President. They are, left to right, son Andy, daughter Beth, and daughter Caroline.

UNIFIED MEMBERSHIP

... Dr Barton and I have traveled thousands of miles together hunting geese. We have observed in this bird some traits that would be useful to us. Geese stick together in flocks for mutual protection and support, thus they are able to achieve their common goal. ...

Speaking after many years of active involvement in KMA, it seems a clear choice to Dr Carlross that the most productive and easiest way to have a voice for medicine is through unified participation. To be relevant, KMA must actively encourage all physicians to come into the fold, to continue to advocate for all physicians regardless of specialty or mode of practice. A main concern involves a recommitment to ethics and professionalism among physicians. "We have differences among specialties and sub-specialties, but there will always be conflict on who should get what, how things should be accomplished, who should be in authority—that is a natural course of physicians and has been throughout time," he says. "Learned people debate for who has the best way, who gets the most, who has the most power. But we share many common issues that *when we stand together we can support and push forward.*"

... When geese stop to rest and feed, several of them are vigilant. They alert the others if something is happening that is of common danger to them. ...

Physicians cannot stand by and watch as the united voice of the lawyers, insurance

companies, and hospital administrators becomes the voice that policymakers listen to. National unification provides physicians with a powerful voice, a voice that must continue to be heard.

Dr Carlross is outspoken when he feels strongly about an issue. "I hear many complaints about the American Medical Association. There are those in my District who tell me the AMA is a lot of old men paid exorbitant salaries to go to nice resorts and give money to Sunbeam. AMA has made mistakes. Any organization will make mistakes. But AMA has tried to stand up for their mistakes and do the right thing in the end.

"The problem of weakened AMA membership is a problem of perception of service. AMA does many things for us that we don't realize because we're not directly involved. AMA does many things for us that we find annoying—such as opening the mail every day and finding another sale of various insurance products. Unfortunately, many people look at the negatives and are not aware of the many positives coming from the AMA. It is the obligation of the AMA and KMA to perform services for the people they take dues from. That may not have been filled on the national level as much as we would like in the past. But now they've identified the problem—it's simply that customers are not satisfied with the service. AMA knows what its task is, and they are formulating a plan of action to accomplish what members want. I foresee improvement.

"When Teddy Roosevelt was running for governor of New York and was in a discussion about labor unions, he stressed the fact that if the union wasn't

going the way you wanted it to go, it wasn't the union's fault, it was your fault because you were a member of the union and you weren't providing adequate guidance to your organization. His message was—if you don't like what's going on you should get involved and change it.

"While I'm President of KMA, I'm going to try to distinguish between members and nonmembers of the KMA. I want to provide service, opportunities, and support for members of the KMA. Hopefully, that will carry through the next few years of the operation of this society."

A LEGISLATIVE YEAR

... Dr Barton and I are only successful in killing these geese when we are able to lure a few of them from the flock with a decoy or a false call. . . .

The son of a vice president/engineer of a utility company and a mother with master's degrees in Latin and mathematics carries a high-achiever pedigree. Harry Carloss downplays his achievements, but there is no denying his background. When it comes to legislative achievements, KMA has made a difference in society, and Dr Carloss is confident that he has what it takes to be a strong link in the chain that perpetuates KMA's making a difference. This confidence is innate. It comes from experience and his thorough enjoyment of tasks that enable him to be of service and to meet and interact with intellectually stimulating and successful people.

"My parents were articulate people, and I was born to them very late in their lives," he says. "We were almost like two separate families, with my brother and sister being much older than me. (My brother will be happy to hear me say that!) While growing up, when my parents went on business trips, I went. I've been with the leadership of the Chamber of Commerce, with national leadership organizations for utility companies, been exposed to Representatives and Senators from the time I was in grade school. I can interface with these people because of past experience. In Dr Peters' 'Future Search,' one of the main things that membership wanted was legislative representation."

Dr Carloss speaks philosophically, "All of life is political—our community, households, family—not just the legislature. Even wolves have political games in their packs. They have pecking orders and they all must learn to adapt to political activities in their communities. Doctors sometimes think they have a monopoly on being controlled and inspected by the government, picked on by the legislature, audited more by tax organizations, but that is not true. Government regulations come with every facet of life, and it's just part of the game. To be successful and accomplish what one wants, one must play the political games. Many people find this distasteful, but to me it's just another requirement for success."

Medicine has had a profound influence on the maturation of the United States commencing with four physician signatures on the Declaration of Independence, and Dr Carloss wants to emphasize the influence medicine has had on this state in which he so proudly serves the profession. "The Kentucky State Legislature passed a law in 1798 to penalize anyone who imported smallpox into Kentucky. They also passed a lottery to build a house for the Kentucky Medical Association, or the precursor of the KMA. So since the beginning of time in our state, as we know it, medicine, the KMA, and the legislature have all been entwined. This is how we are able to influence the legislature. Now, many think that legislators are evil and are out to hurt them. In truth, legislators have a huge responsibility to retain a vast store of knowledge about all activities in the state. We must convince the legislature that we are more knowledgeable about the practice of medicine, health, and disease than anyone, that we want to do the right thing. Only then will we be successful in the legislative arena."

KMA members can be assured that lifelong education and experience have prepared Dr Carloss to be disciplined, realistic, and effective as he responds to legislative matters.

KMA'S 2000 LEGISLATIVE PRIORITIES

Managed care has left many physicians feeling wrung out—stripped of their autonomy and beholden to heartless bureaucracies. President Carloss envisions victories as he lists KMA's priorities for the 2000 Session.

- Countering the evolution in the practice of medicine which is resulting in doctors losing control—"others telling doctors what medical necessity is."
- Patient's rights—"if the patient's rights are protected, then our rights are protected."
- Business matters such as untimely payments. "In Illinois, an insurance company was actually shredding claims and not paying or acknowledging them in any way. There was a huge fine and a whistle blower's settlement. This can be traced on the Internet."
- Vaccinating children. "A main directive of the 1998 House of Delegates was to attempt to establish Kentucky as a universal vaccine state. We've made real progress, but the legislature must budget the money. This will be a major confrontation in the legislature, and we will be relentless in our efforts to help those who cannot help themselves, especially the children."
- Tobacco money settlement. "Almost every organization or person in this state thinks they are entitled to a share. Physicians are entitled to a special share, to have a say on the disposition, because we paid a 2% provider tax on our gross to support Medicaid. The money should go to take care of people, especially children, who are falling between the gaps with the current insurance crisis"

in the state. When it goes into expanding Medicaid, we can get the federal match—\$3 for \$1. When the legislature and the citizens of the Commonwealth realize that we can turn \$100 million into \$300 million and spend it on health care, they will agree that's a wise use of the settlement money."

Dr Carloss heaps praise on KMA's lobbyists. "KMA is very fortunate to have an experienced team of lobbyists who are well respected in Frankfort. They do a yeoman's amount of work with a limited staff, and let me assure you that they represent each of us wherever they go and in whatever they do. They know the ins and outs of the political system and are adept in guiding us through the Frankfort maze. Having observed their success over several legislative sessions, I can't praise them enough. I'm very proud to be associated with them and to have the opportunity to work with them in the 2000 Session."

ALTERNATIVE MEDICINE

... Those who oppose us can only be successful if they can disperse our flock. ...

Dr Carloss is adamant that KMA remain positive and emphasize what doctors do: they do it all, and they're good at it. The bureaucrats, the politicians, and the economists who advocate using less trained people are not looking at it from the patients' perspective. They are only interested in the economic view.

He will be active at the state capitol in 2000, standing firm against any legislation allowing the encroachment of alternative medicine and its practitioners into the realm of medical diagnosis and treatment. "Many groups want to practice medicine, to usurp our authority in taking care of patients and treating health and disease," he affirms. "In our society today, a person turns 50 every seven seconds. This year I'm going to be one of those people. Our generation likes to control things and believes we can do things better than others. Consequently, many are more susceptible to charlatanism than generations dependent on organized structures. This generation is taking a step backward in order to gain more self-control.

"I find it amusing when people talk about natural medicines and how they are harmless," he adds. "Being an oncologist, I use the bark of a yew tree, bacterial extract, and extracts from periwinkle almost every day. A decimal point error can kill you with any one of these. I, of course, refer to them as taxol, adriamycin, and vincristine—but they are all natural! Those attempting to promote natural treatments and cures seem to forget that when they espouse medicine as practiced by the American Indians, that the majority of American Indians were wiped out by smallpox, a disease we have defeated with vaccine.

"Alternative Medicine, what works, what doesn't, will be a hot topic in the legislature," he says. "I believe every individual has the right to try anything they want. But I don't believe it is society's responsibility to pay for ineffective treatments. Money taken out of the system to pay for shark cartilage means less money for vaccines for children. That is wrong."

FAMILY AND LEISURE TIME

My wife, Barbara, is the most valuable thing I got from my education at the University of Kentucky," he says affectionately. "We met in our freshman introduction to biology class, went on a date, and we've been dating ever since! In June we celebrated our 27th wedding anniversary. We have three terrific children, Beth is 23, Caroline is 17, and Andy is 16."

Bird hunting and fishing are the antidotes to Carloss's hectic practice. His family embraces their small town lifestyle. "We live on a farm just on the outskirts of Paducah, and most of my hobbies relate to the outdoors. I grew up hunting and fishing with my older brother and father, and I enjoy fishing and hunting with my son and daughters. Until recently, I participated in a leadership role with a Boy Scout troop in Paducah. But I'm now happy to say I've spent my last night sleeping on the ground! My wife and I also raise bird dogs. We have five Springer Spaniels. They're our surrogate children since our children are maturing and leaving the house."

PRESIDENTIAL LEGACY

Dr Carloss has a genuine desire to find solutions for the woes of a hurting healthcare system. He hopes to employ his one-year presidency to further this effort. "The state is undergoing changes in healthcare, some good, some bad. If we can get through the 2000 legislative session and effectively correct those issues that will improve the health and safety of the people of the Commonwealth and enhance the practice of medicine, I will think I had a successful term."

He is a respected physician of ability and probity, and rest assured that he holds in highest regard the dignity of the office with which he has been entrusted. But when asked how he would like to be remembered as KMA President, Harry W. Carloss, MD, revealed his humorous, lighter side by saying, somewhat tongue-in-cheek, "I would just not want to be the first President of KMA that was impeached!"

This is vintage Carloss, in its pithiness and disarming honesty. Get to know him. He's approachable, he's amicable, he welcomes your camaraderie and support.

... As long as we remain together as one voice for medicine and our patients, those who oppose us cannot win and they will not prevail. ...

— Sue Tharp
Managing Editor



KMA/AMA 2000: A MEDICAL ODYSSEY MEMBER-GET-A-MEMBER CAMPAIGN

Everyone knows that the personal approach is the most effective method of recruiting members.

The impact is even greater when you make the call! The KMA/AMA Member-Get-A-Member

Campaign is designed to assist you in locating and contacting non-members in your area.

You may choose to recruit any physician in your area who has completed medical training and is in active practice, eg, hospital staff colleagues, alumni from your medical school, physicians in your specialty, or nonmembers in a particular target group. You will receive a

Recruitment Kit containing support materials when you sign up.

ENJOY THE REWARDS!

KMA awards for new active KMA members recruited:

1-3 members	Waterman Pen
4-6 members	Franklin Digital PDR
7-9 members	Digital Camera
10+ members	Laptop Computer or \$1500 Computer Accessory Pkg.

AMA awards for new active AMA members recruited:

1-3 members	Quartz Desk Clock / Business Card Holder
4-6 members	Galaxy Radio Alarm Clock
7-9 members	Computer Organizer Bag
10+ members	Palm Pilot

Complete this form and return to Kentucky Medical Association Membership Department to get started today.

☐ Please send AMA materials.

Name _____

Address _____

City, State, Zip _____

Phone _____

Please provide me with a list of potential members based on the following categories:

County: _____

Specialty: _____

Gender: _____

Medical School: _____

Mail to: KMA Membership Dept., 4965 US Hwy 42, Ste 2000, Louisville KY 40222 or call (502) 426-6200.



Carolyn D. Burns, MD

A HOUSE DIVIDED

Government agencies, third party payors, hospital administrators, malpractice attorneys . . . these are only some of the outside forces regulating and influencing our day-to-day practice of medicine. More often than not it seems that these elements pull us in directions contrary to what we might see as best for our patients. Even more disconcerting is that these forces often pit physicians or practices against another.

This undercurrent of physician against physician or practice against practice is a real threat. I view this as equally if not more detrimental to the health of our profession than managed care.

We see it every day. . . physicians arguing over "pieces of the pie," physicians openly disgruntled with their colleagues, practices fighting over contracts, physicians suing other physicians . . . and the list goes on.

Don't doubt for a second that the government, administrators, insurers, and attorneys aren't thrilled to find our Achilles

heel. The house divided will not stand.

Unless we pull our ranks together ever mindful of the true mission of our profession, then the external parties will use it to their advantage. Policies will be made and instituted before our eyes while we stand ensconced in our own internal battles.

We must always attempt to be fair, solicitous, and collegial. We should respect each other's knowledge and contributions to the field of medicine. At times we must also agree to disagree. Despite personal views, we should stand united. Contrary to popular opinion, our profession is not solely a business. Instead, we are in the business of service.

When we took our oaths as physicians we not only vowed to care and respect our patients but also to hold others of our profession in highest regard. It would serve us well to remember that oath.

Carolyn D. Burns, MD

This undercurrent of physician against physician or practice against practice is a real threat. I view this as equally if not more detrimental to the health of our profession than managed care.



Carolyn Daley

AMA FOUNDATION

FOSTERING EXCELLENCE IN EDUCATION, RESEARCH AND SERVICE SINCE 1950

The AMA Foundation distributed over \$2 million in April to US medical schools to support excellence in medical education. The AMA Alliance raised about 90% of the \$2 million through the help of the fund-raising efforts of state Alliances. The AMA Alliance has raised over \$70 million for the Foundation since 1952. The KMA Alliance raised \$46,445.50 of the \$2 million raised by the AMAA in 1998-99. Vicky Borders, 1998-99 KMAA vice-president for the AMA Foundation, did a great job in coordinating the county Alliance fund-raisers.

Each year the KMA Alliance has a state fund-raiser to increase the \$10,000 endowment level of each of two KMAA scholarships. An originally designed quilt was handmade then raffled to benefit the KMA Alliance endowed scholarships at the University of Kentucky and the University of Louisville Medical Schools. That

project raised over \$3200 for the two KMAA endowments. The first scholarships will be awarded this year. In the future, the KMAA hopes to raise the endowed level to support two full-tuition scholarships for first year medical students.

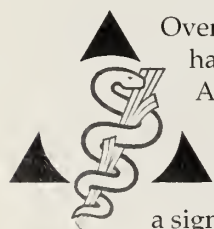
Boyd County, through the fund-raising efforts of county AMA Foundation chair Eloise Meigs, raised \$19,360 last year for the AMA Foundation. Eloise has for many years educated physicians and their families about the importance of giving back to their medical schools. She was presented a lifetime achievement award at the KMA Alliance House of Delegates meeting held in Somerset in April 1999. The KMAA salutes Eloise for her service and dedication to the future of medicine.

Contributions to the AMA Foundation are tax-deductible and may be designated to the

medical school of your choice. The establishment of endowed medical school scholarships may be made through the AMA Foundation. All Kentucky Alliance counties have AMA Foundation Sharing Cards for the holidays or for the celebration of Doctor's Day. The Doctor and Doll card is an additional way to give to the AMA Foundation. If you would like to make a donation to your medical school, please consider giving to the AMA Foundation through the Kentucky Medical Association Alliance. The KMAA has been pleased to win many of the AMAA AMA Foundation awards for our fund-raising efforts to support medical schools.

Thank you for your generosity and continued support for the AMA Foundation.

Carolyn B. Daley
KMAA President



Over the past half century, the American Medical Association Foundation has played a significant role in ensuring that health care in America—and the physicians at the heart of it—remain the best in the world.

The Foundation's philanthropic programs have promoted excellence in medicine through the awarding of more than \$75 million in scholarships and grants to deserving medical students, residents, practicing physicians, and medical researchers. These awards have been made possible through generous contributions from

physicians, their spouses, families, corporations, and other philanthropic organizations.

Today, the Foundation continues to expand its work and increase its positive impact on the medical profession and the patients it serves in three main areas.

Education—The Foundation's scholarship and loan pro-

gram provides vital financial support to medical students who might otherwise be unable to afford a medical school education. The Foundation has helped more than 40,000 medical students.

Research—The Foundation not only funds research into specific medical conditions, but also supports innovative pilot

projects—rarely funded through traditional sources.

Service—Building on its tradition of education and research funding, the AMA Foundation is adding service as a programmatic focus. This decision reflects an understanding of the invaluable role that physicians and their families can,

and do, play in the health and welfare of their communities.

To learn more about the AMA Foundation and how you can lend your support contact:

AMA Foundation
515 North State Street
Chicago, Illinois 60610
1-800-AMA-3211, ext 5357
<http://www.ama.assn.org/>
AMAFoundation

DOCTOR AND DOLL CARD

This beautiful full color card features Norman Rockwell's *Doctor and Doll* image. With a minimum contribution of \$25 per card you can honor someone special with this heart-warming image of the physician. **Remember you are not purchasing just a card, you are making a contribution to the fund/school of your choice in that person's honor, in lieu of flowers or gifts.**

It is appropriate for the following occasions:

- Recognizing physicians on Doctors Day.
- Remembering a birthday, anniversary, or holiday.
- Celebrating a medical school graduation, medical school acceptance, residency or other milestones.
- Thanking physicians and other professionals for their care and services.
- Honoring medical school deans for their efforts during the year.
- Expressing sympathy through a memorial donation.
- Thanking your AMA Foundation chair/committee for all their hard work.

THE SATURDAY EVENING POST



Samuel M. Vauclain - William Hazlett Upson - James Warner Bellah
Wesley Stout - Eleanor Mercein - Samuel Crowther - Booth Tarkington

The *Doctor and Doll* card is in full color with matching envelopes.

This is the inside of the *Doctor and Doll* card:

A CONTRIBUTION TO
THE AMERICAN MEDICAL ASSOCIATION EDUCATION
AND RESEARCH FOUNDATION
HAS BEEN MADE

Use the top two lines to state the reason for the contribution, such as
"In memory of your husband" or "To celebrate 50 years of serving
the medical community."

Fill in the donor's name and address on the bottom three lines.

Contact national headquarters and ask for Harry Bauer. With your minimum \$25 contribution, he will fill out the card and mail it that day.

ANTHEM BLUE CROSS AND BLUE SHIELD

To the Editor:

This is an open letter to the membership of the Kentucky Medical Association. I am writing to apologize for an error which occurred in the recent distribution of a protocol for the use of low molecular weight heparin. That protocol was developed through a consensus process under the sponsorship of the Kentucky Association of Health Plans. I was lead physician on that project. The cover letter mailed mentioned a collaborative effort with the Kentucky Medical Association and the Kentucky Hospital Association. The names

of KMA and of KHA had been removed from the final draft of the cover letter. Unfortunately, the first draft was printed and mailed rather than the cover letter intended. Indeed, I had spoken with Drs Don Stephens and John Stewart and promised that the Kentucky Medical Association would not be mentioned. The cover letter distribution that mentioned the KMA and KHA was an unintended error.

The goal of the development of a consensus protocol was to begin a process whereby greater collaborative efforts between managed care companies and organized medicine could result

in better communication with physicians. This goal remains important. I am hopeful that those of us in the Kentucky Association of Health Plans will continue to work with the managed care committee of the Kentucky Medical Association to streamline processes. Our mutual goal is quality health care for Kentucky citizens.

**Thomas James, III, MD,
FACP, FAAP**
*Medical Director
Anthem Blue Cross and
Blue Shield*

L.C. McCloud, MD

To the Editor:

On July 14, 1999, the people of the Commonwealth of Kentucky lost a physician, medical examiner, dear friend, and advocate for both the living and the deceased. Born November 8, 1929, in Johnson County, Dr McCloud received his BS in Anatomy and Physiology in 1950 from the University of Kentucky and his MD from the University of Louisville in 1955. After a rotating internship and year of training in internal medicine, Dr McCloud spent two years in the US Army Medical Corps, serving in the Canal Zone. Upon his return to the United States, he served as a general practitioner in Martin, Kentucky from 1959—1965, bringing healing to a

chronically underserved area of the Commonwealth. Realizing that his true calling lay in the field of pathology, he returned to Louisville for additional training and subsequently became a faculty member in the University of Louisville's Department of Pathology and Laboratory Medicine. It was there that he quickly established a reputation as a teacher renowned for his depth and breadth of knowledge as well as his avuncular approach to his students.

For 22 years, from July 1977 to July 1999, Dr McCloud served as a Medical Examiner and Forensic Pathologist for the Office of the Chief Medical Examiner in Louisville. In discharging his duties there, he came to be beloved by hundreds of nursing

and medical students, residents, nurses, fellow faculty members, police, emergency medical personnel, attorneys, and others. His work allowed him to give to the wide variety of constituents of a medical examiner the most precious gift a physician can give: peace of mind. That peace came in the form of outstanding work in death scene investigation, the autopsy, and the communication of critical information to medical and related personnel, law enforcement, the legal profession, organ procurement agencies, news media, and other interested parties. He was one to whom the specialists came for answers when even they were stumped. When this writer, as a new resident physician, asked him one day how he seemed to know

more about arcane subjects than even the most experienced specialist, his reply was, "When you read the medical literature for an hour or so every day for 40 years, you learn a thing or two." He was, of course, a lifelong student.

In the quasi-military hierarchy that is medicine, L.C. McCloud, MD recognized no rank other than that of colleague and friend. His amazing abilities and knowledge were tempered by a true humility and love of life and those around him. His example is one for us all, not only in how to continually become a better physician, but in how to live. He joins his wife of 46 years, Betty, in death and is survived by two children and three grandchildren. We are all of us in Kentucky lesser for his loss, but greater for his having been here.

Gregory J. Davis, MD

*Associate Chief Medical Examiner
Commonwealth of Kentucky
Associate Professor of Pathology
and Laboratory Medicine
University of Kentucky
College of Medicine
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Frankfort, KY 40601-8272
502-564-4545 fax: 502-564-1699
gjdavis@pop.uky.edu*

CAGE

Questionnaire

For the Diagnosis of Alcoholism

- C** = Have you ever felt you should **cut down** on your drinking?
- A** = Have people **annoyed** you by criticizing your drinking?
- G** = Have you ever felt bad or **guilty** about your drinking?
- E** = Have you ever had a drink first thing in the morning? (**eyeopener?**)

Positive CAGE Answers:

1 = Suggestive 2 = Probable 3/4 = Diagnostic

**Kentucky Physicians
Health Foundation
502.425.7761**

Kentucky Medical Association 1999 Fall Workshops

CPT Coding: A Comprehensive Study

produced by Adams & Associates, Wanda Adams, CPC

Paducah, Tuesday, October 26 at Information Age Park
Louisville, Wednesday, October 27 at Holiday Inn Hurstbourne
Lexington, Thursday, October 28 at the New Embassy Suites
(All workshops 9:00 am – 4:30 pm local time.)

KMA Members: \$225.00 Non-members: \$260.00
(Includes lunch and materials.)

- Humana began auditing all claims above a level 3 starting August 1!
- HCFA's computerized editing system has more than 80,000 bundling edits!

Can your coding practices stand up to the scrutiny?

Register for this course and:

- examine various sections of the CPT manual
- explore the practical applications of modifiers
- master global surgery applications
- increase understanding of starred procedures
- review CPT code changes

Clinician-Patient Communication to Enhance Health Outcomes

produced by The Bayer Institute

Lexington, Wednesday, October 13 at the New Embassy Suites
London, Wednesday, October 20 at the London Community Center
Louisville, Wednesday, November 3 at the Holiday Inn Hurstbourne
(All workshops 4:00 pm – 8:30 pm EST)

KMA Members: \$145.00 Non-members: \$170.00
(Includes dinner snack and materials.)

- A clinician may conduct as many as 150,000 medical interviews in a typical career!
- Communication affects patient satisfaction and whether legal action is taken!

How do patients feel about your communication skills?

Register for this workshop and:

- raise awareness of the importance of physician/patient communication as an essential aspect of care
- learn the four communication components – engage, empathize, educate and enlist
- practice the procedures and evaluate the outcomes associated with these approaches

Registration Information

To register for these workshops or for more information, call, fax or e-mail KMA at:
Ph: 502/426-6200 Fax: 502/426-6877 e-mail: white@kyma.org

Be sure to include name, practice, address, phone and fax numbers and whether you are a KMA member on registration faxes and e-mails.

KMA BOARD OF TRUSTEES MEETING



Secretary-Treasurer William P. VonderHaar, MD, addressed the group.

The KMA Board of Trustees met in regular session on August 4-5, 1999, at KMA Headquarters Office in Louisville.

KMA President Donald Stephens, MD, reported on recent meetings with the Kentucky Hospital Association and noted the final repeal of the provider tax.

Donald C. Barton, MD, Senior Delegate to the AMA, reported on the AMA Annual Meeting, noting that collective bargaining was the main topic of discussion. Dr Barton also reported on the Washington visit in June and patient protection legislation being debated in the US Senate and House.

Additional reports were presented by William P.

VonderHaar, MD, Secretary-Treasurer; William B. Monnig, MD, Immediate Past Chair, KEMPAC Board of Directors; Preston P. Nunnelley, MD, Kentucky Board of Medical Licensure; and Rice Leach, MD, Commissioner for Public Health. The Board also heard reports from the Ad Hoc Committee on Tobacco Settlement Funds and the Ad Hoc Committee on Cardiovascular Services.

The Board voted to include a \$10 voluntary assessment for the Legal Trust Fund with the 2000 dues billing.

Appointments were made to the KEMPAC Board of Directors, Kentucky Board of Medical Licensure, and the *Journal* Editors Board; and a Judicial Council nominee was approved.

An update was given on the Annual Meeting, nine resolutions were approved for presentation to the House of Delegates, and action was taken on 27 committee reports.

The next meeting of the Board was scheduled for Sunday, September 26, 1999, during the KMA Annual Meeting.



President Donald R. Stephens, MD, left, and Board Chair J. Gregory Cooper, MD, presided over the meeting.

NEWSMAKERS

Steve Aaron, MD, Louisville, has been elected Chair of the Quality Improvement Advisory Council (QIAC) to Medicaid. All of the state's Medicaid Regions report to this Council.

Allan Tasman, MD, Chair of the University of Louisville Department of Psychiatry and Behavioral Sciences, is currently serving as President of the American Psychiatric Association. Dr Tasman also recently completed his second term as the President of the American Association of Chairs of Departments of Psychiatry. He is also a past president of the American Association of Directors of Psychiatric Residency Training and of the Association for Academic Psychiatry. Dr Tasman is the only individual in the history of these major academic psychiatry organizations to serve as president of all three.

Receiving awards for AMA membership recruitment in 1999 were **Baretta Casey, MD**; **Robert Goodin, MD**; **Wally Montgomery, MD**, and **Donald Swikert, MD**.

Eugene H. Conner, MD, contributed nine biographical sketches of physicians, most of whom practiced in Kentucky, to the recently released *American National Biography* (ed John A. Garraty and Mark C. Carnes).

The ANB took 10 years to prepare and was published under

the auspices of the American Council of Learned Societies by Oxford University Press. More than 6,000 contributors wrote 17,450 articles for this biographical dictionary in the field of American history.

Dr Conner's sketches included **John Y. Bassett, MD**; **Asahel Clapp, MD**; **Richard B. Ferguson, MD**; **John P. Harrison, MD**; **John Aaron Cicero Lattimore, MD**; **Joseph M. Matthews, MD**; **Charles W. Short, MD**; **Alban G. Smith, MD**; and **William L. Sutton, MD**.

Western Kentucky University's Alumni Association recently inducted orthopaedic surgeon and Lieutenant Governor of Kentucky **Stephen L. Henry, MD**, into its Hall of Fame.

Beverly Gaines, MD, was elected to chair the pediatric section of The National Medical Association for the next two years.

Dr Gaines is a Louisville area pediatrician and graduate of the University of Louisville.

The National Medical Association is located in Washington, DC, and represents 20,000 African American physicians across the US with 19 science sections.



NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

CHRISTIAN

Singharetnam Wijeyasekaran MD
1910 S Virginia St Ste 106 NEP
Hopkinsville 42240
1983, U of Peradeniya, Sri Lanka

HARDIN

Hanchong John Park MD ORS
1113 Woodland Dr
Elizabethtown 42701
1979, Catholic Med Coll, Korea

HART

Ann Marie Mohapatra MA PD
PO Box 579
Munfordville 42765
1996, U of Kentucky

HENDERSON

Michael Scheinost DO IM
PO Box 678
Henderson 42419-0678
1996, Coll Osteopathic Med & Surgery

JEFFERSON

Karla D. Guess MD AN
3500 Constantine Dr
Prospect 40059
1989, U of Louisville
Liberacion L. Soriano MD AN
1850 Bluegrass Ave.
Louisville 40215
1967, U of Santo Tomas,
Philippines

KENTON

Dianne K. Litwin MD
2900 Chancellor Dr
Crestview Hills 41017
1984, U of Cincinnati

PUD

MASON

Gregory N. Browne MD
991 Medical Park Dr
Maysville 41056
1993, Memorial U, St. John's
Canada

S

Medicine and the Louisville and Kentucky Heart Associations. Dr Pedigo also was past associate editor of *The Journal*. He was named the first physician laureate by the Kentucky Chapter of the American College of Physicians. A 1938 graduate of the University of Louisville School of Medicine, Dr Pedigo was a life member of KMA.

1949 graduate of the University of Cincinnati College of Medicine, Dr Frickman was a life member of the KMA.

Harold M Kramer, MD
Louisville, KY
1915-1999

Harold M Kramer, MD, a retired internist, died August 7, 1999. Dr Kramer was a 1940 graduate of the University of Louisville School of Medicine and an active member of the KMA.

Harry M Roach, MD
Islamorada, FL
1914-1999

Harry M Roach, MD, a retired general practitioner, died May 12, 1999. Dr Roach was a 1940 graduate of the University of Kansas School of Medicine and a life member of the KMA.

Paul C Grider, MD
Louisville, KY
1932-1999

Paul C Grider, MD, a retired internist, died August 13, 1999. His many contributions to medicine included service for several years as Scientific Editor of *The Journal*. A 1958 graduate of the University of Louisville School of Medicine, Dr Grider was an active member of KMA.

OBITUARIES

George W Pedigo, MD
Louisville, KY
1914-1999

George W Pedigo, MD, a retired internist, died July 23, 1999. He was past president of the Jefferson County Medical Society, Transylvania Medical Society, Louisville Society of Internal

Don H Frickman, MD
Taylor Mill, KY
1925-1999

Don H Frickman, MD, a retired internist, died June 27, 1999. A



Kentucky Medical Association

NEW Online features:

LEGISLATIVE SECTION

US/State Legislators – KMA Legislative Policy

KMA ALLIANCE INFORMATION

www.kyma.org — KMA Online

- Hot Topics
- Legislative Policy
- Legal Materials
- Members Only Section
- Annual Meeting
- CME
- Public Info
- Links

Upcoming features:

Membership Roster, Events Calendar

KMA
member@kyma.org



Monitors Ensure Patients Sleep Through a Surgery

As many as one in 50,000 patients may awaken during surgery. A University of Louisville anaesthesiologist is testing a new device that can prevent that from happening.

Gary E. Loyd, MD, is working with the PSA 4000, a device that allows anesthesiologists to check eight different areas of the brain which control sight and hearing. If they see too much activity, they can administer more anesthesia.

The device, which may receive Food and Drug Administration approval in the fall, has an added benefit: because doctors are less likely to overmedicate, patients can wake up sooner after surgery.

AMA and States Show Solidarity on Y2K

All 50 State Medical Societies joined with the AMA in writing Congress to oppose legislation that would hold physicians liable for personal injury claims growing out of Y2K-related problems.

Y2K websites of interest:

- www.fda.gov/cdrh/yr2000/year2000.html—FDA site for Y2K qualified devices

KMA AT YOUR SERVICE

To request *Association* materials referred to in these capsules, contact KMA:

- Phone—502.426.6200
- Fax—502.426.6877
- Email—member@kyma.org

- www.ama-assn.org/notmo/y2k/index/htm
- www.kyma.org—Members Only Guidelines for Protecting your Patient and Practice—AMA

Pharmaceutical Alliance for Y2K Readiness

The Pharmaceutical Alliance for Y2K Readiness is a coalition of drug manufacturers, wholesaler distributors, pharmacies, health care professionals and patient organizations working closely with the government to ensure consumers a continued supply of medication through the Year 2000. The American Medical Association, as a member of the Alliance, has been participating in the coalition's outreach efforts.

The Alliance reports that, during the Y2K transition, this coalition, in conjunction with the President's Council on the Year 2000 Conversion and US Senate Y2K Committee, is confident that the nation's pharmacies will continue to have substantial supplies of prescription medications on hand. As we approach the Year 2000, the Alliance urges consumers to continue to refill their prescriptions as they normally would—when they have a 5 to 7 day supply remaining.

Volunteers Sought for National Breast Cancer Study

U of L's Brown Cancer Center will be among more than 400 sites participating in a new 5-year breast cancer prevention study.

The study will compare the

long-term safety of two drugs, tamoxifen and raloxifene (or STAR) in women 35 or older who are considered at high risk for developing breast cancer. Plans are to enroll 22,000 post-menopausal women in the study designed to find an effective breast cancer treatment with few side effects.

Participants in the random, double-blind study will receive daily doses of either tamoxifen or raloxifene at no cost. Follow-up will include regular mammograms as well as physical and gynecologic examinations.

According to the UofL report, Tamoxifen, which has had Food and Drug Administration approval as a breast cancer treatment for more than 20 years, also has been shown to reduce the chances of developing breast cancer by about 50%.

Findings in the recent breast cancer prevention trial showed that although women on tamoxifen developed fewer fractures, they also were at increased risk of endometrial cancer, deep vein thrombosis, pulmonary embolism and stroke, the report said.

Also, Raloxifene, which currently is used to prevent the progression of osteoporosis, has been shown to increase the risk of deep vein thrombosis and pulmonary embolism, but not endometrial cancer.

For more information, call 502.562.4351.

Government Changing Medicare Form 855

Medicare is in the process of revising the 17-page Form 855,

which is used by physicians to enroll in Medicare. AMA has asked for input regarding difficulties encountered with this Form. If you have recommendations on how Form 855 can be changed, contact KMA.

Gainsharing Arrangements May Violate the Law

The federal government recently published a *Special Advisory Bulletin* in which it notes that "gainsharing" arrangements may violate the law. A gainsharing arrangement is an arrangement in which a hospital gives physicians a percentage share of any reduction in the hospital's costs for patient care attributable in part to the physicians' efforts. The *Bulletin* states that "any hospital payments that induce physicians to reduce or limit clinical services to the physicians' patients" is prohibited under the law. A copy of the *Bulletin* is available. Contact KMA for information.

Flu Season 1999: How You Can Help Medicare Beneficiaries Stay Healthy

The flu season is approaching! Please remember to encourage your Medicare patients to receive their influenza and pneumococcal vaccinations. In most cases, both are Medicare Part B covered preventive health care benefits. Research shows that a provider's recommendation is a strong motivator for a patient to get vaccinated.

A standing order is one example of an effective strategy that a hospital, public health clinic, or nursing home can use to increase immunization rates. For example, physicians could write standing orders in the hospital inpatient setting requiring the assessment and vaccination of all of their Medicare patients. A missed opportunity in the inpatient hospital setting occurs when a beneficiary is discharged without being offered and receiving an influenza and/or pneumococcal vaccination. Missed opportunities can often result in a beneficiary being readmitted to a hospital for influenza and related illnesses, like pneumonia. Please note that a physician's order is not required for Medicare coverage of influenza immunizations, but it is required for coverage for pneumococcal vaccinations.

The most effective strategies for increasing influenza and pneumococcal immunizations involve the health care provider. Simply put, Medicare beneficiaries are most likely to get immunized when their physician specifically recommends vaccination. We ask that providers realize their significant roles and discuss and promote influenza and pneumococcal vaccinations with their patients.

Please remember that while influenza immunizations are seasonal and should be given every year in the fall, pneumococcal vaccinations can be given at any time of the year. Generally, one pneumococcal vaccination after the age of 65 is all that a person needs to protect himself/herself for a lifetime. However, persons who are considered at highest risk, including persons with chronic illnesses, such as diabetes and cardiovascular or pulmonary disease, and people with compromised immune systems, such as chronic renal failure, should ask their doctors if a booster pneumococcal vaccination is necessary. If any person age 65 or older is unsure of his/her pneumococcal vaccination status, revaccination is recommended and will be covered by Medicare Part B.

Thank you for encouraging the proper immunizations and bringing this important preventive health care benefit to Medicare beneficiaries. Health Care Excel has developed a Prevention and Screening Quality Improvement Project to assist you in this task. To request more information on our Prevention and Screening Project, please call Project Specialist Cathie Pritchard, LPN, at 1.812.234.1499, ext 229.

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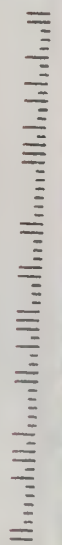
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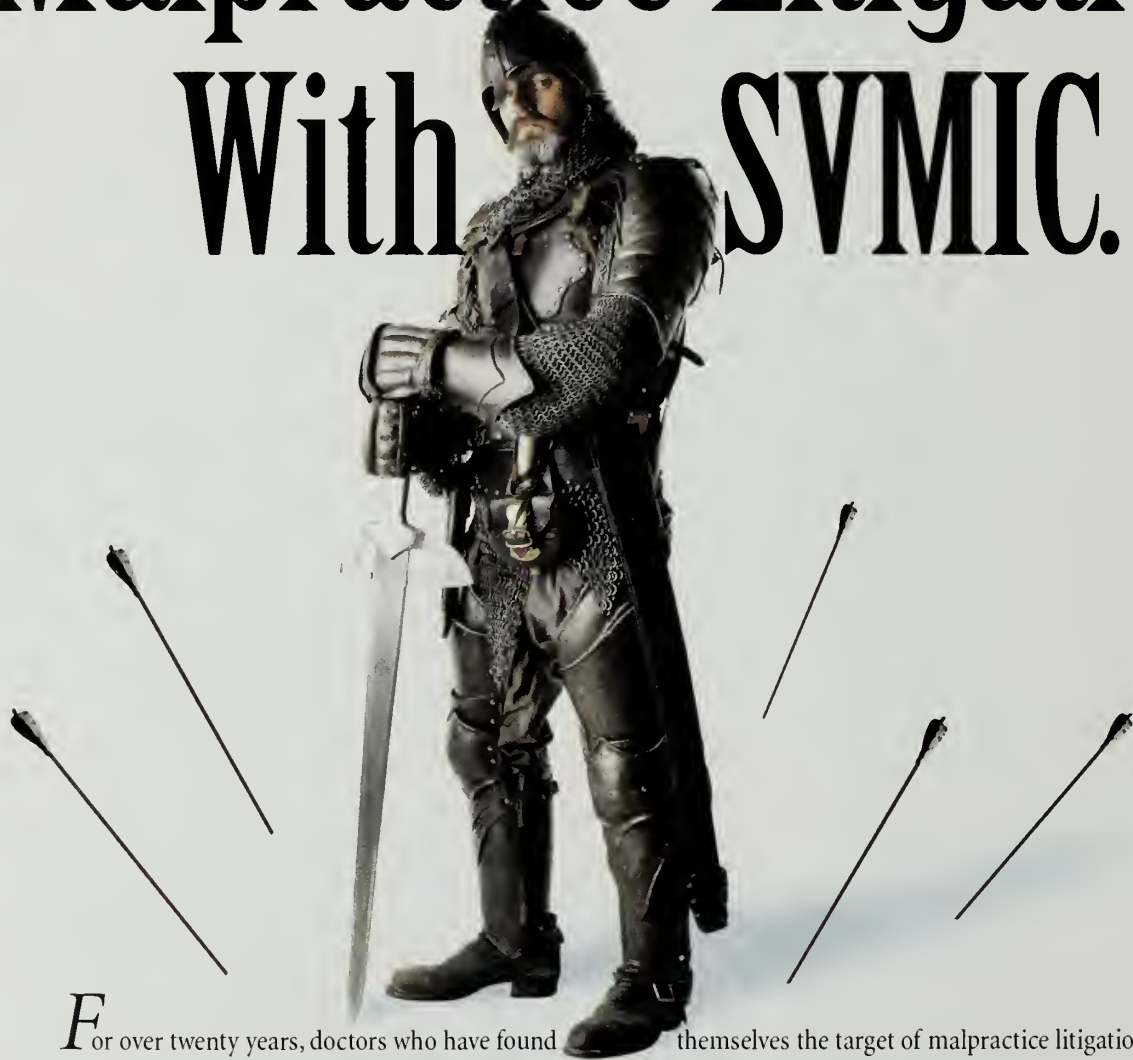
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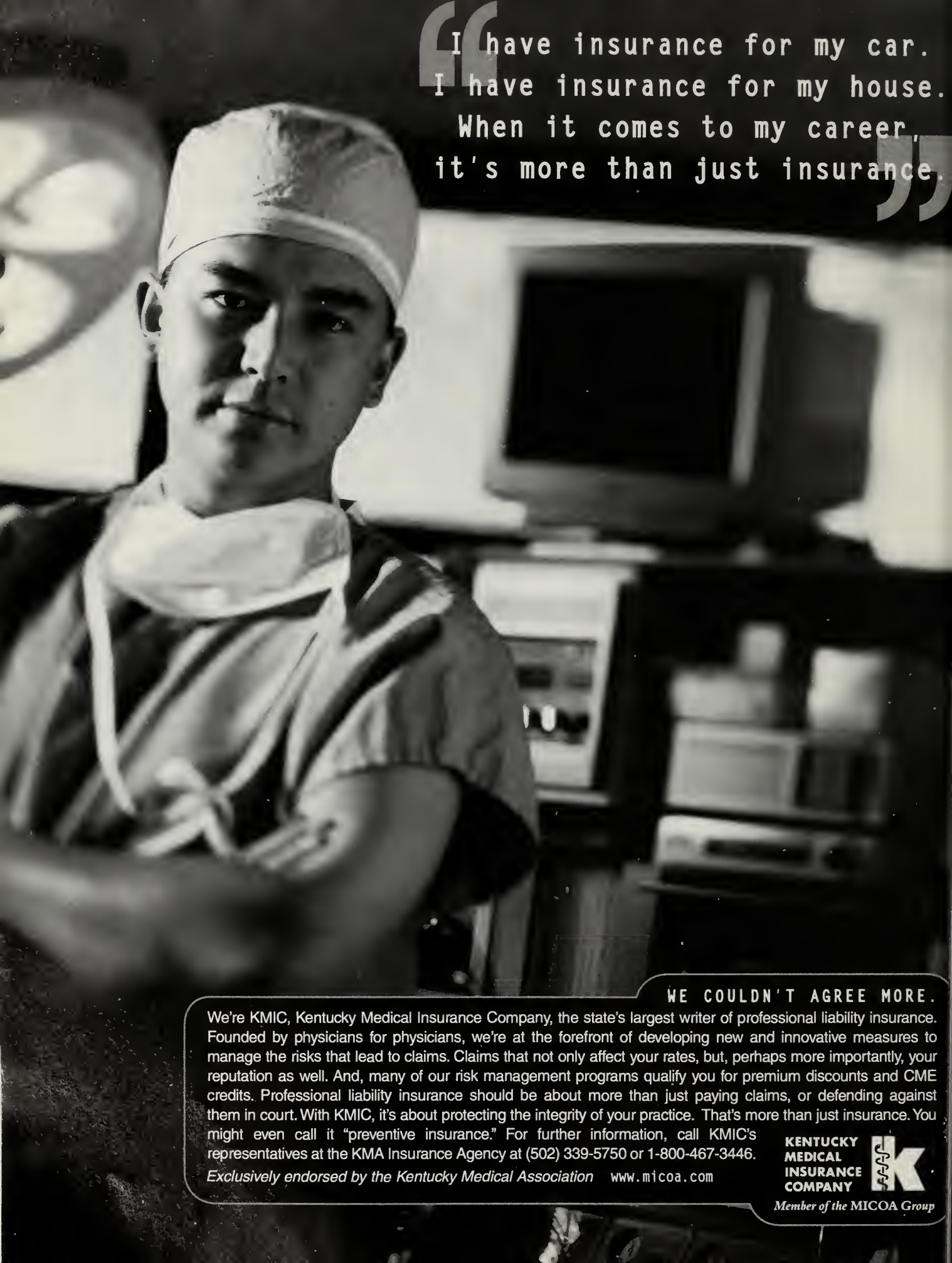
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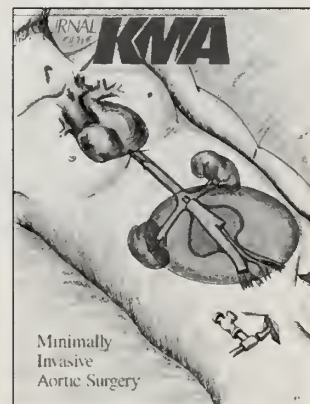
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COVER:

Minimally invasive aortic surgery is now a practical reality. The cover story relates the authors' experience with 150 endovascular stent-graft aortic aneurysm repairs. See page 518.

Artwork by Colleen Nethery

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Listed in *Index Medicus*. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

EDITORIAL AND ADVERTISING: Contact Sue Tharp, JKMA, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222. Phone 502/426-6200; FAX 502/426-6877.

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TASKS AT HAND

The KMA House of Delegates has completed its work for 1999! Resolutions were considered, debated, revised, and passed or rejected on their merits.

Before we talk about specific resolutions, I feel it is necessary to explain how the KMA works. The KMA is a democratic body with delegates elected from each county society based on the number of members from that county. Any delegate or county society may draft resolutions for consideration. Resolutions take the form of *whereas*: giving background information, and *resolved*: listing a statement of action. After introduction, resolutions go to a reference committee where testimony pro and con is heard. After testimony is considered the reference committee chair reports to the House for consideration. There are usually five reference committees made up of members of the House of Delegates. The House then takes action on the resolutions. If a resolution is passed, it becomes KMA policy and governs the actions of the Board of Trustees, staff, and officers of the KMA. So if you don't like policies of the KMA, become a delegate and help form policy for the organization!

Resolutions this year covered a wide variety of topics and are listed below:

Tribute to Richard A. Kielar, MD

Tribute to Richard F. Hench, MD

Tribute to Donald C. Barton, MD

200th Anniversary of the Fayette County Medical Society

Resolution 101—UL Off Campus Teaching Center at Trover Foundation (Hopkins County Medical Society)

Resolution 102—Section Name Change (KMA Resident Physicians Section)

Resolution 103—Repeal of Stark Law (Board of Trustees)

Resolution 104—Mandatory Hospitalist Programs (Board of Trustees)

Resolution 105—Determination of Medical Necessity (Board of Trustees)

Resolution 107—Dues Delinquency Date

(KMA Board of Trustees)

Resolution 108—2000 Member-Get-A-Member Campaign (Board of Trustees)

Resolution 109—Health Education Curricula

(Thomas L. Young, MD, President, Kentucky Chapter, American Academy of Pediatrics)

Resolution 110—Managed Care Compliance (Jefferson County Medical Society)

Resolution 112—Ban All Products Clauses in Kentucky (Jefferson County Medical Society)

Resolution 113—Repeal Free Medical Record Mandate (Jefferson County Medical Society)

Resolution 114—Expand Medical Practice Act to Hold that Medical Review is the Practice of Medicine (Jefferson County Medical Society)

Resolution 115—Anti-Trust Relief (Jefferson County Medical Society)

Resolution 117—Relief for Physicians from Administrative Burdens (Jefferson County Medical Society)

Resolution 118—Tobacco Settlement Allocation (Jefferson County Medical Society)

Resolution 119—Immunizations for Older Americans (Resident Physicians Section)

Resolution 120—Policy Sunset Provision (KMA Board of Trustees)

Resolution 121—Physician Prescribed and Administered Drugs

(McCracken County Medical Society)

Resolution 123—Kentucky State Licensure Requirement for International Medical Graduates (Rajesh K. Sheth, MD, Kentucky Indiana Association of Physicians from India and American College of International Physicians)

Resolution 125—Service Reimbursement During Credentialing (Fayette County Medical Society)

Resolution 129—Cancer Screening (Board of Trustees)

Resolution 130—Kentucky Breast Cancer Task Force (Board of Trustees)

Resolution 131—National Patient Protection Legislation (Board of Trustees)

Resolution 134—Cervical and Colorectal Cancer Screening (Board of Trustees)

Substitute Resolution—Claims Review Programs and Unilateral Offsets (Reference Committee D)



(All Resolutions and Reports presented at the House of Delegates will be published in their entirety in the December issue of The Journal.)

As you can see, the House was busy laying out plans for the year 2000. It was surprising how many resolutions fell under the patient protection category and monopoly or monopsony powers of insurance carriers.

By the time this reaches print, we will know if the Washington political group finally got the message as patient protection bills are to be considered the first week of October.

Coinciding with the KMA meeting, California, the spawning area for managed care, passed sweeping legislation holding HMOs responsible for damage to patients. The lead article in the *Wall Street Journal*, September 28, 1999, discussed physicians deserting the Republican Party because of lack of action on patient protection and control of insurance carriers' dominance in the managed care arena.

During the KEMPAC meeting a Republican State Senator told us "he did not come to the meeting on a turnip truck," then assumed we did when he tried to switch the debate from requiring HMO directions to have a state license and be responsible for their action to the generally undeliverable action on tort reform which requires a constitutional amendment. The will of the people in this country will prevail whether it is through legislation or rejection of politicians in the next election. We must continue our efforts to protect our patients and profession. Doctors *will* decide medical necessity; it is just a matter of when.

Watch your mail for a new KMA feature.

- The booklet *Priorities: for Patients and Their Physicians for the 2000 Kentucky General Assembly*

This useful booklet was presented to 51 legislators at the KEMPAC dinner and all KMA delegates. Further revision may take place before mailing to all KMA members—it is a handbook to discuss with patients, friends, colleagues, the press and, yes, your legislators. Let us know what you think!

During my term as president, I would like to add a new feature to the President's

Page. This month, through cooperation with the Markey Cancer Center and the Kentucky Cancer Registry, I would like to bring to light some facts about malignant melanoma in our state. Melanoma is the deadliest form of skin cancer. In Kentucky, approximately 900 men and women are diagnosed with melanoma every year.

Data from the Kentucky Cancer Registry show that incidence rates for melanoma in Kentucky are higher than the rates from the National Cancer Institute's SEER program, which is often used as an estimate of national incidence rates. The Kentucky incidence rate (14.5 per 100,000) in 1996 was 5% higher than the rate from SEER (13.8 per 100,000) in 1996, the latest year available from SEER.

The graph on the facing page shows melanoma incidence rates in Kentucky for 1992-1997. The increase in the Kentucky rate from 1994-1995 is especially noteworthy. In late 1994, Kentucky began to receive funding from the Centers for Disease Control and Prevention (CDC) to increase completeness of case ascertainment. Therefore, the increase in incidence rates from 1995 over 1992-94 is most likely due to improved case finding, thanks to the cooperative reporting of Kentucky dermatologists and pathology laboratories.

Armed with the information that adjuvant therapy with Interferon improved survival in high-risk patients, physicians intensified efforts to determine a more precise definition of the high-risk patient. Sentinel lymph node biopsy and sampling were investigated and are rapidly becoming the standard of care. For more information regarding this topic please check the following references:

1. Kirkwood JM et al. Quality-of-life-adjusted survival analysis of interferon alfa-2 β adjuvant treatment of high-risk resected cutaneous melanoma: an Eastern Cooperative Oncology Group study. *J Clin Oncol.* 14:2666-2673.
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3. *N Engl J Med.* 1999;340:No. 4.

Harry W. Carloss, MD
KMA President

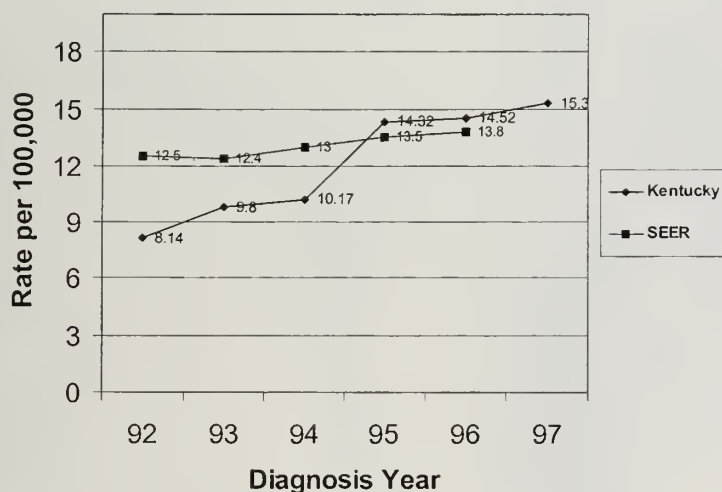
— CANCER CLIP —

KENTUCKY MELANOMA RATES ARE HIGHER
THAN NATIONAL AVERAGE

Melanoma is the deadliest form of skin cancer. In Kentucky, about 900 men and women are diagnosed with melanoma every year.

Kentucky Cancer Registry data show that melanoma incidence rates in Kentucky are higher than melanoma incidence rates from the National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) program, which often is used as an estimate of national cancer incidence. In 1996 (the latest year available from SEER), the Kentucky melanoma incidence rate was 14.5 cases per 100,000 people, which was 5 percent higher than the SEER rate of 13.8 per 100,000.

INVASIVE MELANOMA

Incidence Rates
1992-1997

Source: Kentucky Cancer Registry

The nationally recognized Kentucky Cancer Registry is located at the University of Kentucky Markey Cancer Center.

CONTACT: Steve Wyatt, DMD, assistant director for cancer control, University of Kentucky Markey Cancer Center, 606.323.6541

Cancer Clip is provided quarterly by the Kentucky Cancer Registry.

The sharp increase in the Kentucky melanoma rate from 10.17 in 1994 to 14.5 in 1995 is especially noteworthy (see graph). In late 1994, Kentucky began to receive funding from the Centers for Disease Control and Prevention (CDC) to increase completeness of cancer case reporting. Therefore, the 1995 increase most likely is due to improved reporting by Kentucky dermatologists and pathology laboratories.

Melanoma often begins as a small, mole-like growth that is irregular in shape, grows and changes color. Treatment is most likely to be successful when the disease is found early. Melanoma can be prevented by limiting exposure to the sun between 10 AM and 4 PM, using a sunscreen with a sun protection factor (SPF) of 15 or higher, and wearing shirts and hats to protect the skin.

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MONITORING **Medicine**

NEWS FOR KENTUCKY PHYSICIANS

Overview of the 1999 KMA Annual Meeting

The 1999 KMA Annual Meeting was conducted in Lexington, September 27-29.

The Annual Meeting featured:

- Installation of Harry W. Carloss, MD, Paducah oncologist, as President of KMA.

Elections included:

- William P. Vonderhaar, MD, Louisville family practitioner, President-Elect.
- Andrew R. Pulito, MD, Lexington pediatric surgeon, Vice President.
- Linda H. Gleis, MD, Louisville physical medicine and rehabilitation specialist, Secretary-Treasurer.
- Donald R. Neel, MD, Owensboro pediatrician, Chair of the Board.
- Ardis D. Hoven, MD, KMA Past President and Lexington infectious disease specialist received the Association's Distinguished Service Award.
- Paid tribute to the Fayette County Medical Society on

their 200th Anniversary, the first Medical Society formed west of the Alleghenies.

The KMA House of Delegates convened on Wednesday, September 29, and adopted or recommended the following:

- Called for a study of administrative and paperwork burdens imposed upon physicians and patients by managed care.
- Supported regulations or legislation exempting drugs administered and dispensed by physicians from sales tax.
- Encouraged adequate funding for the U of L off campus teaching center at Madisonville.
- Opposed mandatory Hospitalist programs.
- Recommended that all payers of medical services include cervical and colorectal screening as covered services.
- Recognized the necessity for and expansion of cancer screening and the development of a screening registry.

MONITORING Medicine

- Commended the development of the Kentucky Breast Cancer Task Force.
- Recommended the repeal of Federal "Stark Laws."
- Supported legislation requiring that only physicians determine "medical necessity."
- Recommended that physicians be permitted to charge a reasonable fee for copies of medical records to patients.
- Supported efforts to obtain antitrust relief for physicians to permit collective negotiation with insurance companies.
- Directed KMA support legislation to prohibit "All or Nothing" or so called "All Products" clauses in provider agreements.
- Recommended that managed care compliance should include
 - Establishing criteria for approval of testing
 - Payment for administrative cost of obtaining approvals
 - Published 3 day appeal procedure so that patients are not delayed and the medical office is not placed at jeopardy for mismanagement of the patient's care.
- Encouraged public awareness of the necessity of immunizations for the elderly.
- Established prompt payment mechanisms, including the definition of clean claims, and opposed arbitrary "down coding" of claims by insurers.
- Recommended physicians be reimbursed by insurers while going through the accreditation process.
- Recommended that Phase I Tobacco Settlement funds be allocated as follows
 - 50% to expand Medicaid
 - 15% to transition Kentucky agriculture from a tobacco-based economy to alternative crops and services
 - 15% to early childhood development and children's health and prevention services
 - 5% to provide research grants to Kentucky's medical schools for tobacco-related illnesses
 - 15% to reduce teen smoking, fund smoking cessation and education programs.
- Encouraged the State Board of Education to increase KERA test score weights for health education so that local school authorities will increase health education in school curricula.
- Declared that medical review by a physician constitutes the practice of medicine and should fall under the jurisdiction of the Kentucky Board of Medical Licensure.
- Recommended legislation to require all physicians complete the same residency-training requirement for medical licensure.
- Continued support and encouragement for KMA's Kentucky Physician Care (KPC) program, which has treated over 300,000 patients free of charge since 1985. Recognized the 2000 practicing Kentucky physicians for participating in the KPC.
- Recommended that a plenary session, devoted to issues related to cervical cancer, be held at the 2000 KMA Annual Meeting.
- Adopted an updated policy / guidelines on health system reform.
- Stressed the importance of perinatal smoking cessation, folic acid intake by women of childbearing age, and the importance of newborn screening for congenital adrenal hyperplasia. Also recommended and acknowledged the importance of partnerships in the private and public sector to accomplish these objectives.

Below are synopses of news items that have appeared recently in various publications regarding issues of interest to Kentucky physicians.

- In a significant shift in policy, the Oregon Board of Medical Examiners approved a disciplinary plan for a physician who undertreated pain in six patients. One of the reasons cited for the shift in policy is that dying patients continue to report suffering undue pain. Oregon is the first state medical board to take action against a physician for undertreating pain. [*The Oregonian*]
- In a 4-3 decision, the Ohio Supreme Court struck down as unconstitutional a new tort reform law passed by the Ohio legislature. The law had provisions for limiting punitive damages and noneconomic damages, as well as other provisions. [*Bureau of National Affairs, Health Law Reporter*]
- PacifiCare Health Systems Inc issued a report ranking the quality of care provided by physician groups in the Sacramento, California area. The company graded medical groups on both clinical care and service. The report was released just as employers get ready for open enrollment. [*Sacramento Business Journal*]
- Physician extender salaries are increasing at a faster rate than physician salaries, according to a new survey. While internal medicine physician salaries increased only 0.5%, physician assistant salaries increased 7.1% and nurse practitioner salaries increased 11.1%. [*Hospital and Healthcare Compensation Service*]
- Managed care companies are attempting to control costs by giving physicians financial incentives to prescribe the lowest-cost, most effective medications. Companies pay physicians a flat monthly fee that is used to pay for medications needed by the physicians' patients. Such bonuses, penalties and incentives are under attack from state lawmakers and consumer groups, who believe the arrangements create ethical dilemmas for physicians. The arrangements are popular on the West Coast and becoming more prevalent in the Midwest. [*USA Today*]
- The number of applicants to US medical schools dropped 4.7% between 1998 and 1997. It is the second consecutive year that the number of applicants decreased. Women constituted 43.4% of applicants in 1998. [*AMNews*]
- Medicare contractors are now being looked at as a potential target for Medicare fraud. Eight such companies have paid more than \$275 million to the government to settle charges of defrauding Medicare, falsifying records or using Medicare money to pay costs that should have been paid by private health insurers. Contractors have also filed false claims, improperly destroyed thousands of claims to reduce the backlog of work and simply turned off the telephones when they could not answer customers' calls in the prescribed amount of time. [*New York Times*]

MINIMALLY INVASIVE AORTIC SURGERY: ENDOVASCULAR STENT-GRAFT REPAIR OF ABDOMINAL AORTIC ANEURYSM

Edward V. Kinney, MD; Hermann W. Kaebnick, MD; Richard A. Mitchell, MD; Matthew T. Jung, MD

Minimally invasive surgical therapies are popular with patients and third party payors because they offer increased safety, decreased pain, as well as shorter recovery times and hospital stays when compared to standard open surgery. Minimally invasive aortic surgery is now a practical reality. Our experience with 150 endovascular stent-graft aortic aneurysm repairs at Baptist Hospital East is detailed in the following report. In our practice, stent-grafting is now the treatment of choice for infrarenal abdominal aortic aneurysms within the context of clinical trials.

During the past three decades, the age- and sex-adjusted incidence of abdominal aortic aneurysm (AAA) has tripled. Approximately 3% to 5% of persons over 65 years of age harbor an AAA. This calculates to over one million persons with AAA in the United States. Currently, only about 70,000 AAA are being repaired each year in this country. This discrepancy is related to: 1) inadequate screening (failure to detect the aneurysm); 2) expectant treatment for AAAs less than 4.5 cm in diameter, and 3) patients turned down for elective AAA repair because of poor health. Aneurysm rupture will be the ultimate

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cause of death in 50% of patients who decline or are refused elective AAA repair. Rupture of an abdominal aortic aneurysm remains a leading cause of death in persons aged 55 years and older, accounting for more than 15,000 reported deaths per year in this country. The operative mortality for elective AAA repair in selected patients is 3% to 5%. Post-operative hospital stays in uncomplicated cases are typically 3 to 7 days. At home recovery times for standard open AAA repair are 4 to 6 weeks. Based on this data, the investigation of safer and less morbid methods of AAA repair is justified. The most promising alternative to open AAA repair is endovascular stent-graft repair.

Stent-grafting is a minimally invasive, catheter-based technique for repairing aneurysms from inside the artery ("endovascular"). A stent-graft is a combination of the standard Dacron or PTFE grafts used in conventional open surgery with the metallic stents used to treat coronary and other obstructed arteries by percutaneous approach. Although both of these technologies are well established, their use in combination is new and offers many advantages. Most importantly is the minimally invasive aspect of insertion. Stent-grafts can be introduced into the arterial tree at a site remote (ie, femoral artery) from the abdominal aorta, thus avoiding an abdominal incision. Other potential advantages of stent-grafting include: increased safety, decreased morbidity, shorter hospital stay, and a more rapid return to normal activities.

The purpose of this paper is to describe two clinical trials involving stent-graft repair of infrarenal abdominal aortic aneurysm which are currently underway at Baptist Hospital East in Louisville, Kentucky. Both studies have been approved by the hospital's Investigational Review Board as well as the Food & Drug Administration. Persons who are candidates for these trials have aneurysms which meet certain size and morphological criteria (Table 1). We are conducting two trials so that we can offer treatment to high-risk patients as well as those who are acceptable candidates for open surgical AAA repair.

The first trial is for patients who are acceptable candidates for open surgical AAA repair. In this study, patients are treated with stent-graft devices supplied by Medtronic-AneuRx, Inc, of Cupertino, California. This study is controlled and prospective, but non-randomized.

The second trial is for patients who, because of severe cardiopulmonary disease, are not candidates for open AAA repair or the Medtronic-AneuRx study. In this study, patients will be treated with a device built from currently available vascular grafts and stents by the principle investigator (Edward V. Kinney, MD).

These trials represent the largest experience in the state of Kentucky and one of the largest in the country.

METHODS AND MATERIALS

All patients with arterial aneurysms and suitable anatomy were offered stent-graft repair. Exclusion criteria for the average trial are listed in Table 2. Operative risk was assessed via

Table 1. Inclusion Criteria

- Patient is a candidate for open surgical repair of an infrarenal aortic or aorto-iliac aneurysm, **and**
- has an aneurysm >5 cm in diameter, **or**
 - has an aneurysm 4-5 cm in diameter that has increased in size by 0.5 cm in last 6 months, **or**
 - aneurysm is twice the diameter of the normal infrarenal aorta, **or**
 - aneurysm is saccular and >3 cm in diameter
 - vascular dimensions (eg, aortic and iliac diameters, length from renal arteries to iliac bifurcation and hypogastric arteries) must allow safe access for, and be amenable to treatment with stent-graft device.
 - has minimum neck of 1 cm of non-aneurysmal aorta immediately inferior to the most inferior major renal artery and proximal neck diameter between 18 and 25 mm.

Table 2. Exclusion Criteria

- Patient has an acutely ruptured or leaking aneurysm, or vascular injury due to trauma.
- Patient has conditions that severely inhibit X-ray visualization of the aorta.
- Patient has connective tissue disease (eg, Marfan's Syndrome).
- Patient is hypercoagulable.
- Patient has active systemic infection
- Patient has less than one year life expectancy.
- Patient is unwilling or unable to return for follow-up visits.

COVER STORY

MINIMALLY INVASIVE AORTIC SURGERY: ENDOVASCULAR STENT-GRAFT REPAIR OF ABDOMINAL AORTIC ANEURYSM



objective testing (eg, Persantine Thallium cardiac stress) and medical subspecialist evaluation. Multiple imaging modalities (CT, contrast angiography, intravascular ultrasound) were used to identify patients with anatomy suitable for endovascular repair. Approval was obtained from the Institutional Review Board of Baptist Hospital East and the Food & Drug Administration prior to commencement of this study. Patients were enrolled under two separate

Investigational Device Exemptions: One sponsored by Medtronic-AneuRx, Inc and one sponsored by Edward V. Kinney, MD. All devices were placed by Dr Kinney and associates at Baptist Hospital East, Louisville, Kentucky. The study was prospective and non-controlled. The study began September 1995 and continues currently. Axial CT and color Duplex scanning were used to verify successful aneurysm exclusion following device implantation.



Figure 3. AneuRx device is deployed under fluoroscopic control.



Figure 4. Following deployment, correct position and wall apposition are confirmed by ultrasound and contrast arteriography.

Table 3. Patients (n=150)

- 116 male, 34 female
- mean age 73 (51-90)
- 56 patients were ASA class IV
- 2 patients with "hostile abdomen"

Table 4. Arterial Lesions Repaired (n=172)

- 134 AAA (inflammatory 1) mean size 6.1cm (4.7-11.0)
- 5 graft-iliac pseudoaneurysm
- 23 common iliac aneurysm
- 6 thoracic aortic aneurysm
- 2 thoraco-abdominal pseudoaneurysm
- 1 aorto-esophageal fistula
- 1 popliteal aneurysm

DEVICE DESCRIPTIONS

The Medtronic-AneuRx stent-graft system is modular, that is, constructed from two pieces that fit together, and allows construction of a bifurcated device in-situ. Each component is fully-stented, self-expanding, and constructed from polyester graft material and Nitinol, a metal known for its ability to reform its shape at body temperature.

Our device is also modular, fully-stented, and self-expanding. Each component is constructed from stainless steel Gianturco-Z stents and balloon-expanded Impra ePTFE vascular grafts. Our system does not allow in-situ construction of a bifurcated device, so patients with an inadequate distal aortic neck were treated with an aorto-uniiliac device and standard femoral/femoral bypass.

IMPLANTATION PROCEDURES

All patients were treated in the Peripheral Vascular Surgical Suite at Baptist Hospital East. The suite is a standard operating room in the surgery suite with a permanent ceiling-mounted Siemens Multistar digital fluoroscopy unit. All procedures were performed under general endotracheal anesthesia. Prior to induction of anesthesia, arterial monitoring, central venous access, and a bladder catheter were placed. The patients were positioned supine and a standard prep was performed including the left antecubital space. The left brachial artery and both femoral arteries were also exposed. A short 6F sheath was placed in the brachial artery and a 90 cm, 5F pigtail catheter was placed at the level of the superior mesenteric artery via the brachial artery. Retrograde femoral artery catheters were also placed. A 6F, 12.5MHz CVIS intravascular ultrasound catheter was then used to size the aorta and iliac vessels. Contrast angiography was used to identify the location of the renal and hypogastric arteries. Stent-graft devices were delivered over the wire from a retrograde femoral approach using 18-24F Desileth-Hofman sheaths (Cook) (Figures 1-4). Following device deployment, intravascular ultrasound

and contrast angiography were used to verify complete wall apposition and correct axial location. Supplemental balloon dilatation and additional stents or stent-graft devices were occasionally used to accomplish complete aneurysm exclusion.

RESULTS

During the course of this study, 156 procedures were performed on 150 patients (116 male, 34 female) to repair 172 arterial aneurysms (Tables 3 & 4). The mean patient age was 72.3 years (range: 51-92). Fifty-six patients were ASA class four (Tables 5 & 6). Two patients were considered to have "hostile abdomens" (multiple ostomies and previous irradiation). These 58 patients were considered very high risk for conventional open aneurysm repair.

All 92 patients in the normal risk group recovered and were discharged home on the first or second postoperative day. Five patients in the high-risk group died in the perioperative period (perioperative mortality 3%). Procedural time was less than 210 minutes without complication and with blood loss less than 800 cc in 4 of 5 patients. Death was attributed to severe pre-existing cardiac disease in 3 patients. One patient had chronic renal insufficiency and his family refused to allow dialysis postoperatively. One perioperative death was secondary to atheroembolization. Post-mortem examination was performed in all cases and confirmed correct device placement. Three surviving patients had postoperative congestive heart failure (one secondary to myocardial infarction) which prolonged their hospital stay. Mean procedure time was 210 minutes for the entire study group (range 65-390 minutes). Mean procedure time for the Medtronic-AneuRx device was 147 minutes. Mean blood loss was 450 cc (range 50-3000 cc). Mean hospital stay was 3.5 days (range 1-12 days) for the entire group.

Devices were successfully placed in all 150 patients. Follow-up CT scans at one week and one month identified three patients with persistent perigraft flow (endoleak). Thus the primary technical and clinical success was 98% (early

Table 5. American Society of Anesthesiologists (ASA) Scale for Anesthesia Risk

- ASA I No systemic disease
- ASA II One system, well-controlled disease
- ASA III Multiple-system disease or well-controlled major system disease
- ASA IV Severe, incapacitating disease
- ASA V Imminent danger of death

Table 6. Study Patients ASA IV

● severe, unreconstructable CAD	26
● COPD (FEV1, home O2)	20
● VALVULAR HD	4
● CHILD'S C CIRRHOSIS	2
● METASTATIC MALIGNANCY	2
● combined HD & COPD	2

endoleak rate 2%). All three early endoleaks occurred in patients treated with custom-made devices (3/60, 5%). In three patients, an endoleak was identified on follow-up CT scan performed > 6 months postoperatively (late endoleak rate 2%). These patients had been treated with an AneuRx device (3/90, 3% endoleak rate). The overall endoleak rate was 4% (three early and three late). Five of six endoleaks were repaired successfully using endovascular techniques. Ultimately, all aneurysms were successfully excluded, although secondary procedures were required in the six patients with endoleaks. One patient with a late leak came to open repair. Thus, the secondary technical and clinical success was 99.3% to date (Table 7).

There were five deaths in the follow-up interval. Three deaths occurred about 3 months postoperatively and were secondary to myocardial infarction. Post-mortem examination verified persistent aneurysm exclusion in all patients. Two patients died of cancer.

The remaining 140 patients are alive and well at a mean follow-up of 14.5 months. All 140 patients have repaired aneurysms, verified by both CT and color Duplex examination.

DISCUSSION

Stent-graft repair of infrarenal abdominal aortic aneurysm gained worldwide attention in

Table 7. Results, Stent-Grafting for Arterial Aneurysms, Baptist Hospital East

Primary Technical Success	147/150	(98%)
Endoleaks	6/150	(3 early, 3 late)
Endoleaks corrected with endovascular procedure	5/6	
Secondary Clinical Success	149/150	(99.3%)
Mortality	5/150	(3.3%)
Renal Failure	2/150	(1.3%)
Arterial Rupture	2/150	(1.3%)
Embolization	2/150	(1.3%)
CHF	2/150	(1.3%)
Hospital Stay	mean 3.5 day	(1-12 day)

1991 when Parodi et al published the results of his first 68 human implants.¹ Since that time, many significant advances have occurred in device design and construction, delivery systems, imaging, and technique. Currently, at least seven companies are pursuing FDA approval. In Europe, where the approval process is less involved, over 3000 aneurysms have been repaired with stent-graft devices. In the US, less than 2000 implants have been performed.

Stent-grafting is a safer, less morbid treatment for infrarenal AAA than conventional, open surgery. We have used this modality to treat 58 patients who had been refused conventional repair because of severe heart or lung disease. Five of 58 (8.6%) "high-risk" patients died in the preoperative period. An operative mortality of 8.6% is just under the published acceptable upper limit of 10% for open aneurysm repair. Since the mortality of untreated AAA is 50%, we believe stent-graft repair is the best option for "high-risk" patients.

Among the 92 "normal-risk" patients, there were no perioperative or late deaths, and most patients left the hospital on the first or second postoperative day. All patients, irrespective of risk, were very satisfied with the treatment. All patients had returned to normal activities by 2 weeks, postoperatively.

Our experience with the Medtronic-AneuRx bifurcated stent-graft device is part of a prospective, non-randomized multicenter trial comparing open surgical repair to stent-graft repair for the treatment of infrarenal abdomi-

Table 8. Results, U.S. Multicenter AAA Trial, Open Repair vs Aneurx Stent-Graft (12 study centers)

	Stent-graft (n = 190)	Surgical (n = 60)	p value
Technical success	97%	100%	ns
Mortality	1.3%	0%	ns
Major complications	12%	23%	<0.05
Procedure time	3.1 ± 1.3hr	3.6 ± 1.6hr	ns
Blood loss (ml)	641 ± 636	1596 ± 1432	<0.05
Transfusion	12%	40%	<0.05
ICU days	0.9 ± 1.2	2.5 ± 3.1	<0.05
Extubation(d)	0.1 ± 0.3	0.9 ± 2.3	<0.05
Regular diet(d)	1.4 ± 0.9	5.1 ± 2.5	<0.05
Hospital stay(d)	3.4 ± 2.7	9.4 ± 10.8	<0.05
Endoleaks at 6 months	9%		

nal aortic aneurysm. Zarins et al have recently presented the data from our study.² Stent-graft repair was shown to be equal to open repair in terms of safety and efficacy. Furthermore, stent-graft repair was associated with a need for fewer transfusions, more rapid airway extubation, a shorter ICU stay, more rapid progression to a regular diet, less time to independent ambulation, and consequently a shorter hospital stay (Table 8).

Concerns have been raised as to the durability of the procedure. The short term (>3

years) results have been highly favorable. One specific concern raised is the possibility of continued expansion of the infrarenal aortic neck unseating the device. While theoretically possible, this has not been born out by the clinical results. No late leaks have developed at the proximal attachment site in our series, and no changes in aortic neck dimension have been documented on serial CT scans.

We believe that stent-grafting represents a significant advance in the treatment of arterial aneurysms because it avoids the abdominal incision and its accompanying morbidity. FDA approval of this technology occurred September 28, 1999. We are currently treating about 75% of our infrarenal abdominal aortic aneurysms with stent-grafts.

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2. AneuRx stent graft versus open surgical repair of abdominal aortic aneurysms: Multicenter prospective clinical trial. Christopher K. Zarins, MD; Rodney A. White, MD; Donald Swarten, MD; Edward Kinney, MD; Edward B. Diethrich, MD; Kim J. Hodgson, MD; and Thomas J. Fogarty, MD, are the investigators of the Medtronic AneuRx Multicenter Clinical Trial, Stanford, CA.

SKULL BASE RECONSTRUCTION UTILIZING TITANIUM MESH IN CHRONIC CSF LEAKAGE REPAIR

Gregory Mick, DO

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Objective and Importance—Chronic cerebrospinal fluid leakage is a perplexing management problem in skull base surgery, as well as craniofacial and certain otolaryngologic procedures. When all less invasive techniques have been tried and have failed, craniotomy for direct repair is often done.

Clinical Presentation—This case represents one such case in which the pathology found required an unusual application of a common surgical adjunct for correction. The patient in question had experienced CSF rhinorrhea intermittently for 10 years prior to presentation. Several intracranial procedures had failed to curtail the rhinorrhea, after failure of lumbar drainage and other less invasive procedures had also failed. The patient was taken to surgery again for an attempt to directly correct the CSF leak, after demonstration of the location of the leak was accomplished with the assistance of contrasted coronal CT images of the anterior fossa. **Technique**—At the time of surgery, comminuted fractures of the floor of the anterior fossa were noted. These fractures were associated with multiple sites of dural impingement. Following meticulous repair of all dural injuries, reconstruction of the floor of the anterior fossa was accomplished with the use of titanium micro mesh. The mesh placement isolated the dura from further contact with the fracture surfaces, preventing recurrent dural injury. **Conclusion**—The use of titanium mesh in skull base surgery has previously been reported in craniofacial and cranial vault procedures. Its use in skull base applications may prove useful in certain situations. This patient remains asymptomatic nearly 2 years after its use, longer than with any previous procedures to correct his chronic CSF leakage.

fluid leakage may result in delayed or poor wound healing, chronic cephalgia, brain abscess, meningitis, and other complications. Its diagnosis and management represent a challenge to those treating patients with CSF leakage.

Advances in imaging techniques including MRI, 3 dimensional CT reconstruction and high resolution isotopic cisternograms have all added to the surgeon's armamentarium in treating this problem effectively. We present a case in which a new application for existing technology may contribute to the effective treatment of this often perplexing problem.

Case Report

This 62-year-old man presented with a history of chronic rhinorrhea thought to be caused by cerebrospinal fluid leakage. He had been involved in a train-truck collision some 10 years earlier and had sustained multiple craniofacial injuries. These injuries resulted in CSF rhinorrhea. He had undergone lumbar drainage, ventriculoperitoneal shunt, and two craniotomies in an effort to correct the chronic CSF leak, to no avail. The last craniotomy included extensive cranioplasty with methylmethacrylate for cranial defects.

Physical examination revealed hand wave acuity only in the right eye. No papilledema was seen in either eye during fundoscopic examination. Visual acuity, light, and accommodation reflexes were normal on the left as well. Facial symmetry was noted, and sensation in the face was normal. Gag and corneal reflexes were intact, as was the shoulder shrug. Extra-ocular movements were normal and the patient was anosmic. Motor and sensory examinations and reflexes were normal. Plantar response was bilaterally flexor. No rhinorrhea

The problem of cerebrospinal fluid leakage is never ignored by the neurosurgeon, craniofacial surgeon, or otolaryngologist. It becomes a significant management issue in trauma, sinus surgery, reconstructive facial procedures, and skull base procedures. Chronic cerebrospinal

was seen at the time of examination, while the remainder of examination was unremarkable.

A CT scan of the head was obtained to reassess the status of the ventricles following the placement of a ventriculoperitoneal shunt, since if ventriculomegaly was present, revision may have been indicated. However, no ventricular enlargement was seen.

A water-soluble contrasted cisternogram with thin cut coronal CT scan was obtained which delineated the location of the leak at the cribriform plate, favoring surgical correction.

DESCRIPTION OF THE PROCEDURE

The patient underwent a bifrontal craniotomy for repair of multiple dural tears, reconstruction of the anterior fossa skull base floor utilizing titanium mesh, and reconstructive cranioplasty utilizing titanium plates.

Upon completion of a bifrontal craniotomy, satisfactory brain relaxation was achieved with the administration of mannitol. Minimal retraction of the frontal lobe was performed, exposing the floor of the anterior fossa. Numerous areas of impingement of the dura were found, asso-

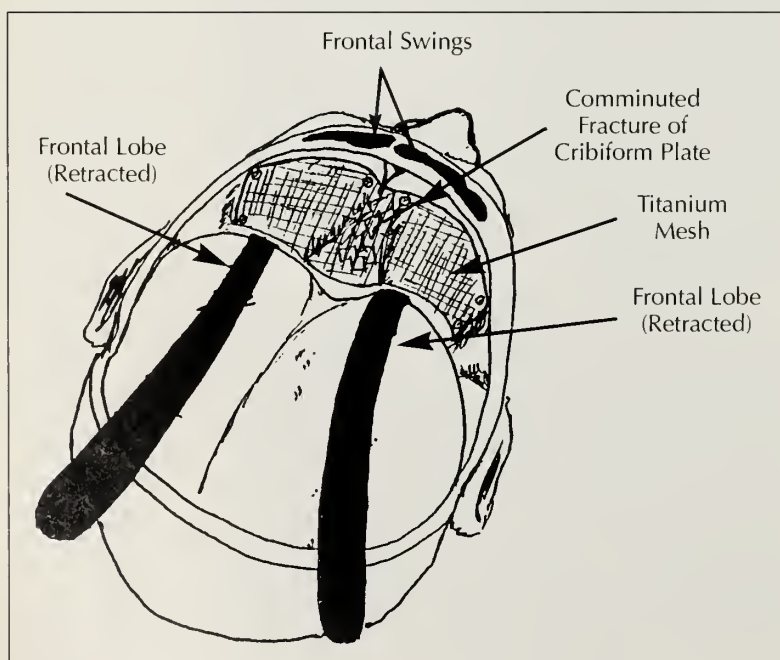
ciated with multiple comminuted fractures of the floor of the anterior fossa. Additionally, several fragments of free methylmethacrylate were found epidurally. Each location of dural impingement was amputated, then closed with 4-0 nuroton in a watertight fashion. The frontal sinus was completely exenterated and packed with Bacitracin soaked gelfoam, after which it was packed with adjacent fat and sealed with fibrin glue. Removal of all remaining methylmethacrylate was accomplished. A piece of titanium mesh was then fashioned to conform to the exposed portion of the anterior fossa floor, placed over the fracture sites, and secured with micro screws. Gelfoam was placed over the mesh and fibrin glue spread over the construct. The craniotomy flap was replaced with an additional cranioplasty being performed using stainless steel plates. The patient tolerated the procedure well with no new neurologic deficits seen. No evidence of CSF rhinorrhea was seen in the perioperative period. The patient is now nearly 2 years post-op and remains free of CSF leakage.

DISCUSSION

The problem of CSF rhinorrhea is a vexing one. As a sequelae to trauma, neurosurgical, ENT, or plastic surgical procedures, CSF leakage provides the opportunity for bacteria to gain egress into the intracranial space. Any subsequent brain abscess has potentially devastating consequences.

Equally frustrating can be the diagnosis of CSF leak. Differential diagnosis of CSF leakage includes chronic seasonal rhinitis, epistaxis, sinus infections, and otitis media without tympanic membrane rupture. Diagnosis of CSF leakage first requires a high index of suspicion. The occurrence of drainage from the nose or ear in the setting of post operative period or post trauma setting should alert physicians to the possibility of CSF leakage.

Several methods to assess this problem are available. The simplest, though of questionable reliability, is the occurrence of a "halo sign." Suspect drainage is dripped into filter paper. If



a dual pattern develops with the bloody fluid in the center and a clear fluid circle of greater diameter, then the drainage is assumed to be CSF. B transferrin is found in CSF but not in tears or nasal exudates, and this can be determined with protein electrophoresis. These methods, however, do not localize the actual source of the leakage. It is necessary to know as precisely as possible the location intracranially of the leak, in order that treatment can be correctly planned.

A Nuclear Medicine Cisternogram (Indium) is done to help confirm and localize the source of the CSF leak. This test involves a lumbar puncture and Indium injection with a delay to allow circulation of the isotope through the CSF. Isotope cisternograms may not give sufficient detail and specificity to assist in surgical planning. However, they can confirm the existence of a CSF leak.

Our preference for diagnosis and preoperative planning is thin cut coronal CT scanning of the suspect area with water soluble contrast cisternography. This technique also requires lumbar puncture and a delay to allow contrast circulation, but gives much improved detail. Actual representation of what will be seen intraoperatively can be produced with 3D reconstruction.

Once diagnosis is confirmed, non operative treatment options include lumbar drainage, ventriculoperitoneal or ventriculoatrial shunting if hydrocephalus is concomitantly seen, and the use of acetazolamide short term to reduce CSF production. If these measures fail to correct the problem, then surgical correction and repair of the CSF fistula is undertaken.

This paper describes a new application for the use of Titanium mesh in neurosurgery. The use of Titanium mesh is well documented in the literature for craniofacial and skull vault applications. In addition, it can be a safe and effective technique in certain skull base procedures, as Titanium is MRI compatible, relatively inert, malleable, and easy to fashion into appropriately shaped implants.

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PROFESSIONAL COURTESY— A FEDERAL OFFENSE?

Patrick T. Padgett, Esq

Professional courtesy. The age-old practice of providing free or reduced cost medical care to other physicians and their families. It is a time-honored tradition in medicine and one that seemed to be untainted by the draconian practices of managed care and government regulation. But no longer. Professional courtesy is under attack by the government, and physicians are perplexed at how such an innocent practice may be considered a federal offense.

This article explains the legal theories regarding how professional courtesy may violate the law. Nothing in this article, however, is intended to serve as legal advice. Physicians are encouraged to consult with an attorney knowledgeable in health care law for answers to specific questions.

PROFESSIONAL COURTESY

Professional courtesy began in the 18th century and was designed to provide free medical care to deceased physicians' widows and families. In the 19th century, professional courtesy was mandated as an ethical responsibility, but that mandate was dropped from the AMA Code of Ethics in 1957.¹

Professional courtesy is the practice of providing free or reduced cost medical services to another physician or the physician's family. Some physicians also provide professional courtesy to others in the medical

field including nurses, office personnel, and hospital employees. It is usually provided by either waiving the patient's copay or deductible, or by providing services at no charge. As discussed below, either of these types of professional courtesy can create legal problems for physicians.

PROFESSIONAL COURTESY AS A FALSE CLAIMS

The most dangerous area for physicians to be caught in allegations of fraud and abuse is in the submission of claims. If a physician claims additional payments from the government above what is allowed for a particular service, it may be a violation of federal law. The federal False Claims Act prohibits a person from knowingly submitting false or fraudulent claims in order to secure payment from a federal healthcare program.² The law was passed during the American Civil War to ensure that government contractors could be prosecuted for submitting inflated claims for payment of goods provided to the government. In the past, this law was used against other government contractors, but it has recently become very popular in the health care field because of the number of health care claims submitted to the government each year. The penalties for violating this law include a civil penalty of up to \$10,000 for each

violation (\$10,000 for each claim submitted); treble damages (three times the amount of the claim); and, payment of the costs associated with bringing the action.³

So how can giving a colleague professional courtesy violate the False Claims Act? Most professional courtesy is given by charging the patient "insurance only," in which any deductible or copayment is waived and the office accepts whatever the insurance company is obligated to pay. According to the government, any waiver of a copay or deductible for anyone participating in a federal health-care program may constitute a violation of the federal False Claims Act. How? Waivers of coinsurance and deductibles may be a misstatement of the actual charge for a service. For example, if a physician's charge for a service is \$100 and he agrees to accept 80% from Medicare, he is to receive \$80 from Medicare and bill the remainder to the patient. But if he waives the \$20 copayment, he has reduced his charge to \$80. The carrier, therefore, should be paying 80% of \$80, rather than 80% of \$100. This theory was outlined in a government publication known as a "fraud alert," which is meant to inform the medical community of practices the government considers to be illegal. This particular fraud alert was issued in 1991.⁴ There is no exception under this theory for professional courtesy. In fact, the government

and legal commentators have consistently maintained that professional courtesy violates the law.⁵

The federal False Claims Act only applies to claims submitted to a federal healthcare program. If professional courtesy in the form of "insurance only" is given to someone who has private insurance, as opposed to government sponsored insurance, is waiving copays or deductibles still illegal? Perhaps. Kentucky has a state law prohibiting false claims from being submitted to private insurance carriers.⁶ If the same analysis regarding how professional courtesy violates federal law is applied to state law, thus extending the analysis to private insurance carriers, the practice would be illegal.

Is there any way to get around this law? One way is to give professional courtesy in the form of "free care," which means the services provided to a colleague are given in exchange for no payment of any kind. If the insurance company or federal program is not billed, there is no claim submitted that may be considered "false." Thus, free professional courtesy may be all right, *unless* it's given to a colleague who is in a position to refer patients to the physician who provided the free care. In that case, such professional courtesy may violate the federal Anti-Kickback law.

PROFESSIONAL COURTESY AS A KICKBACK

The federal Anti-Kickback law prohibits medical providers, as

well as patients, from offering, paying, soliciting, or receiving "remuneration" (ie—kickbacks) to induce business for which payment is made under a federal health care program.⁷ In other words, no one can give or receive money to refer a person, or be referred, to a provider if payment for the services is going to be made by a federal health care program.

What is considered to be a "kickback" has been interpreted quite broadly. One federal appeals court has said, "If one purpose of the payment was to induce future referrals, the Medicare statute has been violated."⁸ The Departmental Appeals Board has also ruled that a kickback is "anything of value," which could be interpreted to mean cash, donuts or free medical care.⁹ The government's use of the Anti-Kickback law in prosecuting physicians has become very popular in the last few years. Several investigations have led to prosecutions and convictions of physicians.¹⁰

How can professional courtesy in the form of free care violate this law? According to the Anti-Kickback statute, no one may give or receive anything of value in exchange for a referral. If a physician provides free or discounted care to another physician who is in a position to provide referrals to the treating physician, it may be looked upon as providing something of value to the physician in exchange for a referral.

PROFESSIONAL COURTESY—THE FUTURE

It is unclear what the new legal climate surrounding professional

courtesy means for the future of this time-honored medical tradition. Many believe that professional courtesy is no longer needed because those it was designed to help—physicians' families—now have adequate medical insurance. The number of uninsured continues to rise each year and many argue that such people are the ones in need of free or reduced-cost medical care, not physicians' families. With many practices suffering financially from the pinch of managed care, some argue that a large professional courtesy practice could have a substantial financial impact on a medical practice. And then there are those who argue that professional courtesy should be abolished because, in many respects, "you get what you pay for." Those who have taken advantage of professional courtesy in the past say they were leery of calling their physician because they did not want to bother a physician who might feel obligated to provide free care. This, of course, could be problematic if there is an immediate need for medical care.¹¹

As this article has discussed, there are legal pitfalls in providing professional courtesy. Medical practices should be careful in how they provide it, if they decide to provide it at all.

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2. 31 USC §3729.
3. *Id.*
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Routine Waiver of Copayments or Deductibles Under Medicare Part B, Issued May 1991.

5. *Physician Compliance Alert*, Vol 1, No 7, Apr 12, 1999. This publication cites a federal government official as saying that "physicians often think 'who cares' about professional courtesy, but insurers do care and it is an issue."
6. KRS 304.47.020.
7. 42 USC §1320a-7b(b)
8. *US v Greber*, 760 F2d 68 (3rd Cir 1985)
9. *Inspector General v Hanslester Network*, CCH Medicaid and Medicare Guide § 39,566, Departmental Appeals Board, Appellate Division, Dec. No 1275 (Sept 18, 1991).
10. See *US v Addis*, CA 7, No 98-2221, 12/8/98, in which a physician received a three year prison sentence for receiving kickbacks from a hospital. See also *US v Anderson*, D. Kan, No 98-20030-JWL, 4/5/99, in which two physicians were convicted of accepting illegal kickbacks from hospitals.
11. *Rethinking Professional Courtesy*, *supra* note 1.

Patrick Padgett is the Director of Socioeconomic Affairs/Staff Counsel for the Kentucky Medical Association.

If you would like a copy of the Fraud Alert cited in this article that deals with the waiver of copayments and deductibles, contact the KMA.

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To the Editor:

From November 1995 through May 1997 members of the Tuberculosis Control Program of the Cabinet for Health Services visited health departments statewide and assessed the management of patients with tuberculosis. We concluded that, in general, practices fell short of meeting the guidelines published by the American Thoracic Society and Centers for Disease Control and Prevention.¹ In the past two years the TB Control Program increased its educational efforts for local health departments and community physicians. A second survey completed in June 1999 shows significant improvement in several key areas (Table). These include the use of four-drug short

course therapy, use of DOT (directly observed therapy), obtaining or offering HIV antibody testing, obtaining appropriate chest radiographs, and improving follow-up skin testing of contacts. While significant improvement has been made, some areas can still be improved. For instance, further emphasis should be placed on better monitoring of patients on ethambutol and more careful follow-up to ensure sputum conversion.

Physicians and health department personnel throughout Kentucky should be commended for their management of patients with tuberculosis. It is through the efforts of persons such as these that the incidence of tuberculosis in Kentucky has

fallen from more than 10 cases per 100,000 to the current incidence of 4.6 cases per 100,000, which is below the national average.²

Martin E. Evans, MD

Associate Professor of Infectious Diseases

*Department of Internal Medicine
University of Kentucky
Lexington, KY*

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Table. Comparison of TB management practices before and after educational efforts

Parameters and/or Time Limits	% Met 1997 (n = 207)	% Met 1999 (n = 44)	Difference 1997-1999	P value (Fisher's Exact)
<i>Initial patient database</i>				
History and physical exam documented	73	89	15	<.05
Tuberculin skin test (TST) results recorded	85	86	1	NS
Diagnostic chest radiograph within 7 days of visit	89	95	7	NS
Diagnostic sputum (≥ 3 specimens) within 14 days of first visit	80	91	12	NS
Culture source, date, results, and antibiotic sensitivities recorded	66	93	11	NS
<i>Drugs</i>				
Initial empiric use of four antibiotics at proper dosage	25	72	20	<.05
Regimen consistent with sensitivity testing	83	92	9	NS
Completion of therapy timely	43	58	19	<.05
<i>Compliance</i>				
Directly Observed Therapy (DOT) attempted	38	64	26	<.05
<i>Laboratory and drug toxicity assessments</i>				
HIV testing offered or done	39	57	18	<.05
Initial AST, then repeated if signs or symptoms of hepatitis if patient on isoniazid, rifampin, or pyrazinamide	56	88	32	<.05
Visual acuity and red/green color discrimination screening, then screened monthly if on ethambutol	43	54	10	NS
Baseline audiometry and balance exam, then clinical assessment of hearing and balance monthly for aminoglycosides	46	25	-21	NS
<i>Follow-up sputum bacteriology</i>				
Monitor with 3 sputa biweekly until smear negative on three consecutive days, then monthly until 3 cultures negative	55	65	9	NS
If smear positive after 3 months, reevaluate for resistance or noncompliance	62	53	-9	NS
Insure conversion to negative	71	71	1	NS
<i>Follow-up chest radiographs</i>				
Repeat if new signs or symptoms	75	87	11	NS
Repeat at completion of therapy	56	88	32	<.05
<i>Contact investigation</i>				
Close contacts: TST ≤ 7 days of index case identification	67	73	5	NS
Close contacts: repeat all neg TSTs ≤ 12 weeks	23	57	34	<.05



Stephen Z. Smith, MD

E-MEDICINE

"E-medicine" tackles the next century, and you better be prepared. Computers hum their processors, from II to III and beyond, faster and more facile, while like the Model T Ford coming to the average person in an affordable package. Initially we physicians gladly adopted this technology, since mega storage freed our memories from having to catalogue, maintain, and reproduce volumes of information. Megabytes bettered mega-brains when it came to fast and thorough recall. Data flashed from monitors, populating hospitals, lounges, and offices, where with fingers touching keys a patient's medical course could be rapidly followed. If the hardware looked flashy and colorful, bigger and more fleet, the evolving software greased the engines. Codes buried in disks or CD-ROMs tweaked better and ever expanding applications for conducting medicine. Programmers concocting even more tantalizing results whetted our appetite for improved functions.

Just when the Information Age seemed to be maturing, along came the Internet and the

world's axis started tilting. Cyberspace connected people previously isolated or without means. That patients are more informed and armed with questions and suggestions could be easily anticipated. To the degree that this mutual interaction between the physician and patient produces better results and keeps the relationship even closer, this development is good for medicine. Support through mutual experience and sharing makes patient support groups interacting through the Internet a powerful ally.

For physicians all this happens at the time of expansion in information and technology and contraction in the money to pay for it. Our continued education must be pertinent and efficient. Here the strength of the virtual lecture hall brings current teaching 24 hours a day. With an ISP or modem and a few appropriate clicks, the mouse and the brain become bed partners. This intimacy can open the way to highways of new places, anywhere in the world. Pictures digitized in Germany light up the 17-inch color monitor in

A potpourri of anecdotal experience and questions comes in discussion groups and chat rooms. That may be the 21st century curbside consult. Current medical education may be renamed instant medical education.

Louisville. A potpourri of anecdotal experience and questions comes in discussion groups and chat rooms. That may be the 21st century curbside consult. Current medical education may be renamed instant medical education. This instrument, like a laser or endoscope, should be quickly and enthusiastically embraced, if we are to participate in the new medical world.

E-commerce grabbed the Wall Street pinstripes by the lapel and changed their way of doing business. Well, our business has also changed and rapidly those lacking computer and Internet ability will be handicapped, if not immobile.

Stephen Z. Smith, MD

American Medical Association Organized Medical Staff Section (AMA-OMSS)

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* Must be an AMA member

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Carolyn Daley

“PLANT A SEED ... READ!”

November 15-21, 1999, is National Children's Book Week. This year's theme is "Plant A Seed ... Read!" Since 1919 Children's Book Week has been celebrated during the week before Thanksgiving. In 1919, Franklin K. Matthews, librarian of the Boy Scouts of America, expressed a need for a national book week to promote reading and quality children's books. The Children's Book Council is a non-profit organization which was organized in 1945 to encourage literacy and the reading of children's books. The Council promotes National Children's Book Week in order to increase the awareness of literacy and the joys of reading. Some celebrations of Book Week have included dressing up as children's book characters in plays, or in libraries; a poetry festival; book sharing; book drive; celebrate books and authors; have an annual week of no TV; reading with the family; and reading with friends. The Children's Book Council produces a catalogue for ordering posters, bookmarks, etc in order to help promote the book week celebration: 1/800.999.2160. Proceeds from the items sold help to support the literacy efforts of the Book Council. Their website for ordering materials:

www.cbcbooks.org

Good literacy skills are essential for the development of one's life potential. Businesses are in great need of a literate work force. Medical families can help by providing children's books in the waiting rooms of physicians' offices, clinics, and hospitals; by having a book drive to give books to families who do not have books in their homes; and by physicians prescribing reading to babies and young children. The rewards of reading will last a lifetime. The Kentucky Medical Association Alliance is promoting literacy and reading to infants and young children. Child development can be greatly enhanced by reading to children. We want every Kentucky child to have this educational advantage.

As we prepare to celebrate the Thanksgiving season, let us give some thought to the role that literacy has played in our lives. Medical families are blessed with the love of learning. During the next century, the next millennium, can we say, "Every Child A Reader"?

Have a wonderful Thanksgiving.

Carolyn B. Daley
KMAA President



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PHYSICIAN'S RECOGNITION AWARDS

Listed below are KMA member physicians in Kentucky who have earned the AMA's Physician Recognition Award (PRA) from August 1998 through July 1999.

The Award was established by the AMA House of Delegates of the American Medical Association in 1968 "to encourage physician participation in continuing medical education and to recognize physicians who have voluntarily completed programs of continuing medical education." In December 1992, the AMA House of Delegates revised the requirements for the PRA. Physicians now have two choices for PRA certification—the standard certificate and the PRA certificate "with Special Commendation for Self-Directed Learning." A minimum of 150 credit hours of CME must be earned over a consecutive 3-year period to qualify for the Standard PRA Certificate. Of these 150 hours, at least 60 must be in AMA/PRA Category 1. Ninety hours of education can be in Category 2 which

Anderson

Kenneth E. Hines, MD

Barren

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Warren J. Eisenstein, MD

Boone

Donald J. Swikert, MD
Kimanh T. Vu, MD

Bourbon

Emmett L. Tate, MD
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Saroj B. Dubal, MD

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Van R. Jenkins, MD
Karl C. Kelty, MD
Dennis R. King, MD
Thomas S. Moore, MD
Patrick J. O'Hare, MD
Charles L. Papp, MD
Christian N. Ramsey, MD
Daniel P. Reese, MD
Richard Salcido, MD
Nat H. Sandler, MD
Shawn M. Taylor, MD
Russell L. Travis, MD
Woodford S. Van Meter, MD
James R. Woody, MD

Floyd

Narong Chalothorn, MD

Franklin

James M. Fetter, MD
Rice C. Leach, MD

Grant

Darl B. Shipp, MD

Grayson

Victor F. Duvall, MD

Hardin

Henri C. Richard, MD

Harlan

Sandford L. Weiler, MD

Hart

Kevin L. Flowers, MD

Henderson

Noel D. Canlas, MD
James M. Stearns, MD

Hopkins

Richard C. Bauer, MD
John R. Ewing, MD

Jefferson

William R. Bradford, MD
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Norman K. Cohen, MD
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Barbara M. Freeman, MD
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Lisa R. Kirsch, MD
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Donald R. Lewis, MD
Steven J. Lichtenstein, MD
Robert W. Linker, MD
Martin D. Mark, MD
Daniel L. Menkes, MD
Soraya P. Nasraty, MD
Philip E. Podruch, MD
Prasun C. Ray, MD
Michael R.O. Recto, MD
Richard N. Redinger, MD
Andrew C. Renz, MD
Walter L. Sobczyk, MD
Robert E. Solinger, MD
Bernard L. Speevack, MD
James L. Sublett, MD
Juan Villafane, MD
Jeff L. Wampler, MD

includes CME lectures and seminars not designated Category 1; medical teaching; articles, publications, books, and exhibits; and nonsupervised CME such as self-instruction, consultation, patient care review, and self-assessment. Credit hours are based on hour-for-hour participation in a continuing medical education activity with the number of hours rounded to the nearest whole hour. For the AMA PRA Certificate with Commendation, the requirements differ from the Standard Certificate in that applicants cannot include reading of medical literature as qualifying for Category 2 and applicants had to obtain a minimum of 20 credit hours of Category 1 and 20 credit hours of Category 2 annually.

We congratulate these physicians who have distinguished themselves and their profession by their commitment to continuing education.

Kenton

Amy S. Haney, MD
Christine Horner-Taylor, MD
Victor Schmelzer, MD

Laurel

Daniel A. Chung Tze Chong, MD
Thomas Mechas, MD

Lawrence

Lee A. Balaklaw, MD

Madison

Clifford F. Kerby, MD

Marshall

Wendell E. Gordon, MD
R. J. Phillips, MD

McCracken

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John A. L. Patton, MD

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William L. Miller, MD
Kristy L. Wells, MD

Perry

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Pike

Harry E. Altman, MD
Kenneth T. Grimes, MD
Rakesh Sachdeva, MD
Remedios M. Valera, MD

Rockcastle

Kimberly Cornelius, MD

Russell

Richard S. Miles, MD

Taylor

David E. Bentley, MD

Warren

Mark T. Alberhasky, MD
John C. Tapp, MD

Whitley

William C. Briscoe, MD

NEWSMAKERS

Two KMA members were included in the group chosen as Kentucky Young Leaders for the 21st Century. **Lisa M. Daniel, MD**, of Louisville, is an emergency room physician at Baptist East Hospital and **Kelly M. McMasters, MD**, of Louisville, is a surgeon and Weakley Professor of Surgical Oncology at the University of Louisville.

Peter E. Tanguay, MD, a UofL professor of psychiatry, received the Norbert and Charlotte Reiger Award for Scientific Achievement from the American Academy of Child and Adolescent Psychiatry (AACAP) for a paper he wrote on autism.

Charles B. Spalding, MD, received a 1999 Salute Award, which celebrates the educational contributions of Catholic school alumni, from the Archdiocese of Louisville.

Peter J. Kambelos, MD, Boone County, has been appointed to the board of directors of the Northern Kentucky Independent District Health Department.

The late **Claire Louise Caudill, MD**, a prominent physician known for her work in rural Kentucky, is the subject of a new book titled *Country Doctor* (University Press of Kentucky).

OBITUARIES

Edgar S Weaver, MD
Carrollton, KY
1912-1999

Edgar S Weaver, MD, a retired general practitioner, died June 24, 1999. Dr Weaver was a 1938 graduate of the University of Louisville School of Medicine and a life member of KMA.

Joseph H Saunders, MD
Lexington, KY
1910-1999

Joseph H Saunders, MD, a retired ophthalmologist, died September 7, 1999. A 1937 graduate of Tulane University School of Medicine, Dr Saunders was a life member of KMA and was a past president of Fayette County Medical Society.

Dewey E Cummins, MD
Brooksville, KY
1926-1999

Dewey E Cummins, MD, a retired general practitioner, died September 7, 1999. Dr Dewey was a 1953 graduate of the University of Louisville School of Medicine and a life member of KMA.

Lewis T Peyton, MD
Louisville, KY
1908-1999

Lewis T Peyton, MD, a retired general practitioner, died September 16, 1999. A 1932 graduate of the University of Louisville School of Medicine, Dr Peyton was a life member of KMA.

Orson P Smith, Jr, MD
Louisville, KY
1923-1999

Orson P Smith Jr, MD, a retired radiologist, died September 18, 1999. Dr Smith was a 1947 graduate of Columbia University College of Physicians & Surgeons and a life member of KMA.

"PEOPLE"

The Journal's "People" Section publishes short items on KMA members' awards, honors, elections, and other noteworthy events and accomplishments. We encourage you to send notices and photographs to:

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FDA Approval to Proceed With Clinical Trials on Inhalation Chemotherapy For Treatment of Lung Cancer

Battelle recently announced that the US Food and Drug Administration (FDA) has granted approval for the initiation of Phase I clinical trials on its inhalation chemotherapy treatment for lung cancer and tumors which have metastasized to the lung.

Key to Battelle's approach is a new device and procedure, which allows controlled delivery of the drug to the lung without contaminating the environment and exposing the therapists to toxic chemotherapy drugs.

Phase I clinical trials will involve low doses of doxorubicin in patients who have cancer in their lungs which is not treatable by conventional means. The first trial will be conducted at Memorial Sloan-Kettering Cancer Center in New York with additional trials expected to begin at other leading cancer centers later this year. The National Cancer Institute is collaborating with Battelle on this program. Phase I clinical trial work is targeted for completion in late 2000.

Battelle Pulmonary Therapeutics (BPT) is a for-profit subsidiary of Battelle Memorial Institute.

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To request *Association* materials referred to in these capsules, contact KMA:

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FDA Approves New Dose of Baycol® For The Treatment of Elevated Cholesterol

Bayer Corporation, Pharmaceutical Division, recently announced the Food and Drug Administration's (FDA) approval of a 0.4 mg strength of Baycol® (cerivastatin sodium tablets) as the recommended dose for patients with primary hypercholesterolemia (elevated cholesterol) and mixed dyslipidemia (elevated cholesterol and high triglycerides). According to the announcement, this new dose will be available at the same price as the 0.3 mg dose of Baycol.

Interprofessional Code

The preamble of the Interprofessional Code of the Kentucky Medical Association and Kentucky Bar Association, as revised in 1984, was last published in the November 1997 *Journal of KMA*. To request a copy of the preamble, contact KMA.

AMA Video Available on Medicine as a Career

The AMA and Association of American Medical Colleges have produced a 12-minute video, "Science and Art in the Name of Healing," which physicians can use in presentations to high school or college students on choosing medicine as a career. Contact AMA at 1/800.621.8335 to order.

KMA Seeks Funding to Designate Kentucky a Universal Vaccine State

KMA leadership met recently with Governor Paul Patton and Cabinet Secretary Crit Lwellyn to request funding to designate Kentucky a Universal Vaccine state. Resolution 98-123, as adopted by the KMA House of Delegates, directed that KMA pursue implementation of the Universal Vaccine program in Kentucky. The convening of a KMA Ad Hoc Committee composed of pediatricians, public health officials, along with leadership to study the issue, preceded the meeting with the Governor.

As a universal vaccine state, childhood vaccines would be made available to all children at no cost. Physicians would be permitted a fee to administer the vaccine. Governor Patton indicated interest in the program and agreed to give it serious consideration in his 2000-01 Biennial budget.

Medicaid Department To Seek Refunds From Physicians

The Department for Medicaid Services contracted with a company known as "Sapient" to review claims submitted to Medicaid over the last 3 years to find potential discrepancies, whether major or minor.

Based on Sapient's findings, Medicaid plans to send letters to many physicians around the state requesting refunds. An appeals

process will be set forth in the letter from Medicaid and physicians are encouraged to carefully review the notices and appeal the refund amounts. KMA will provide additional information on this issue when it becomes available.

Health Plan Concern? AMA Wants to Hear From You

The Private Sector Advocacy (PSA) Group of the American Medical Association has opened two new conduits for physician contact. A toll-free hotline at 800/262.3211 and an interactive web page—www.ama-assn.org/advocacy/psadvocacy/index.htm—are available to receive questions and concerns about the health care marketplace and practices of health plans.

Information Received From Humana Health Plan on Claims Audit Procedures

Humana has instituted a procedure to audit certain claims. The purpose is to ensure that claims are paid at the appropriate level according to coding guidelines and medical record documentation. Medical records are being evaluated by a billing coder under the supervision of a physician. Standard CPT coding guidelines issued by HCFA in 1995 are used to determine the correct claim code.

- Claims submitted as levels 4 and 5 will be reviewed.
- For these claims, letters are sent requesting copies of medical records. The physician will

be given 14 days from the date of the letter to fax or mail a copy of the records for review.

- If a review of the medical records supports the code billed, the claim will be processed.
- If the medical records are not received within 14 days, the claim will be adjusted to a level 3 and processed with the following message code:

"MO" Reduced payment has been made due to lack of supporting medical documentation. If supporting documentation on this claim is available, please fax to 877/250.1758 within 30 days of the date of this notice for reconsideration.

- If a review of the medical records does not support the code billed, the claim will be recoded and processed for payment with the following message code:

"KO" Payment was adjusted based upon review of the claim and/or medical records. If additional information on this claim is available, please fax to 877/250.1758 within 30 days of the date of this notice for reconsideration.

- If the claim is recoded and the physician disagrees with the change, additional documentation may be submitted for appeal. This documentation should support the key components identified in the CPT definitions that determines the various codes. The information may be faxed to Humana at: 877/250.1758.
- If you have any questions, please contact your Provider Relations Representative at Humana Health Plans.



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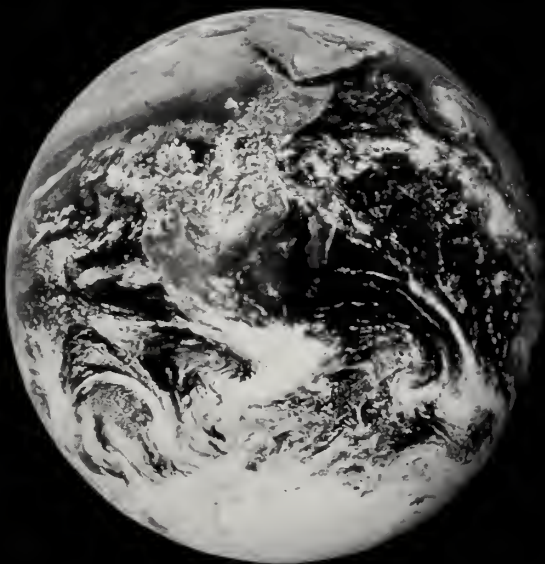
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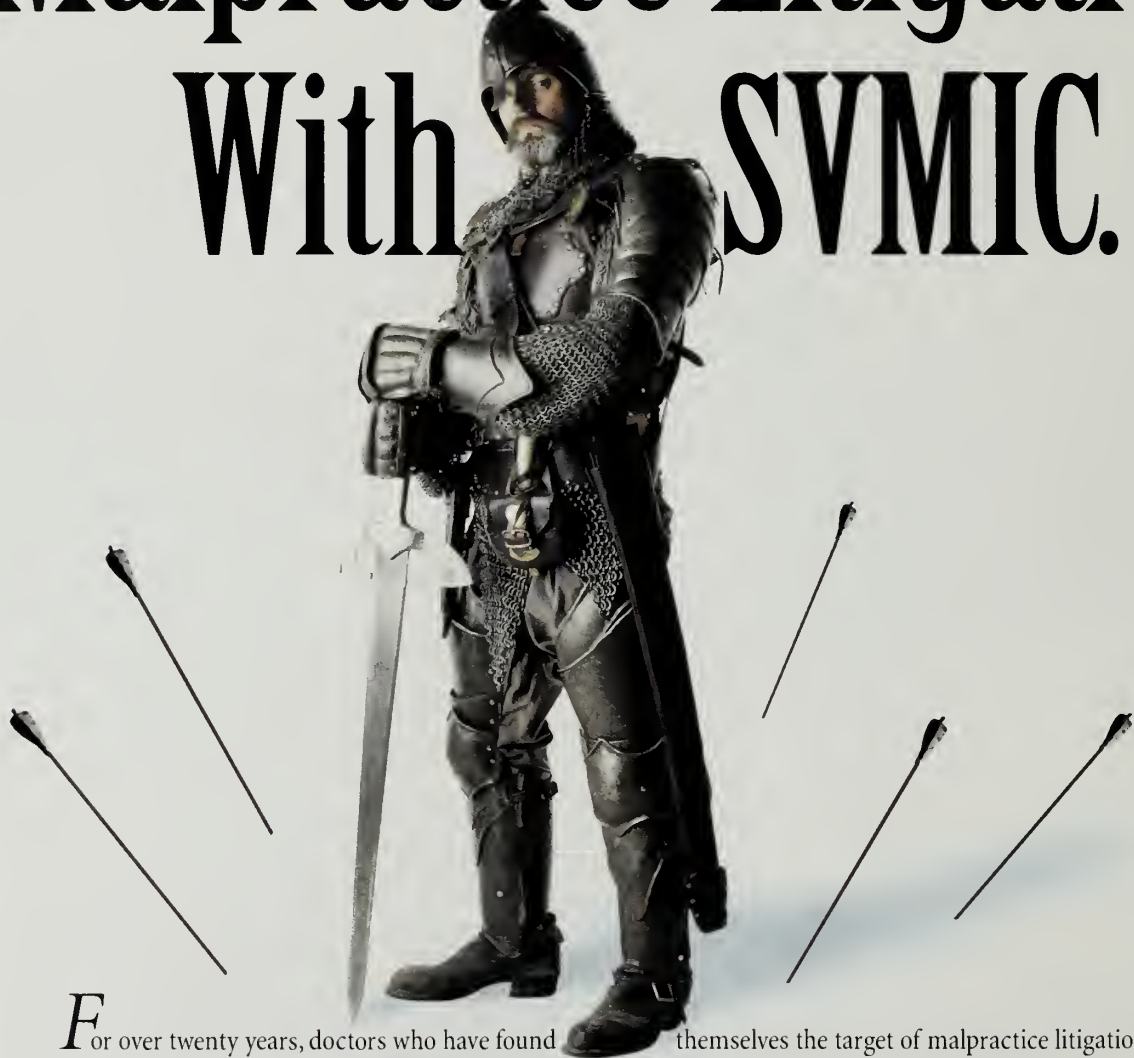


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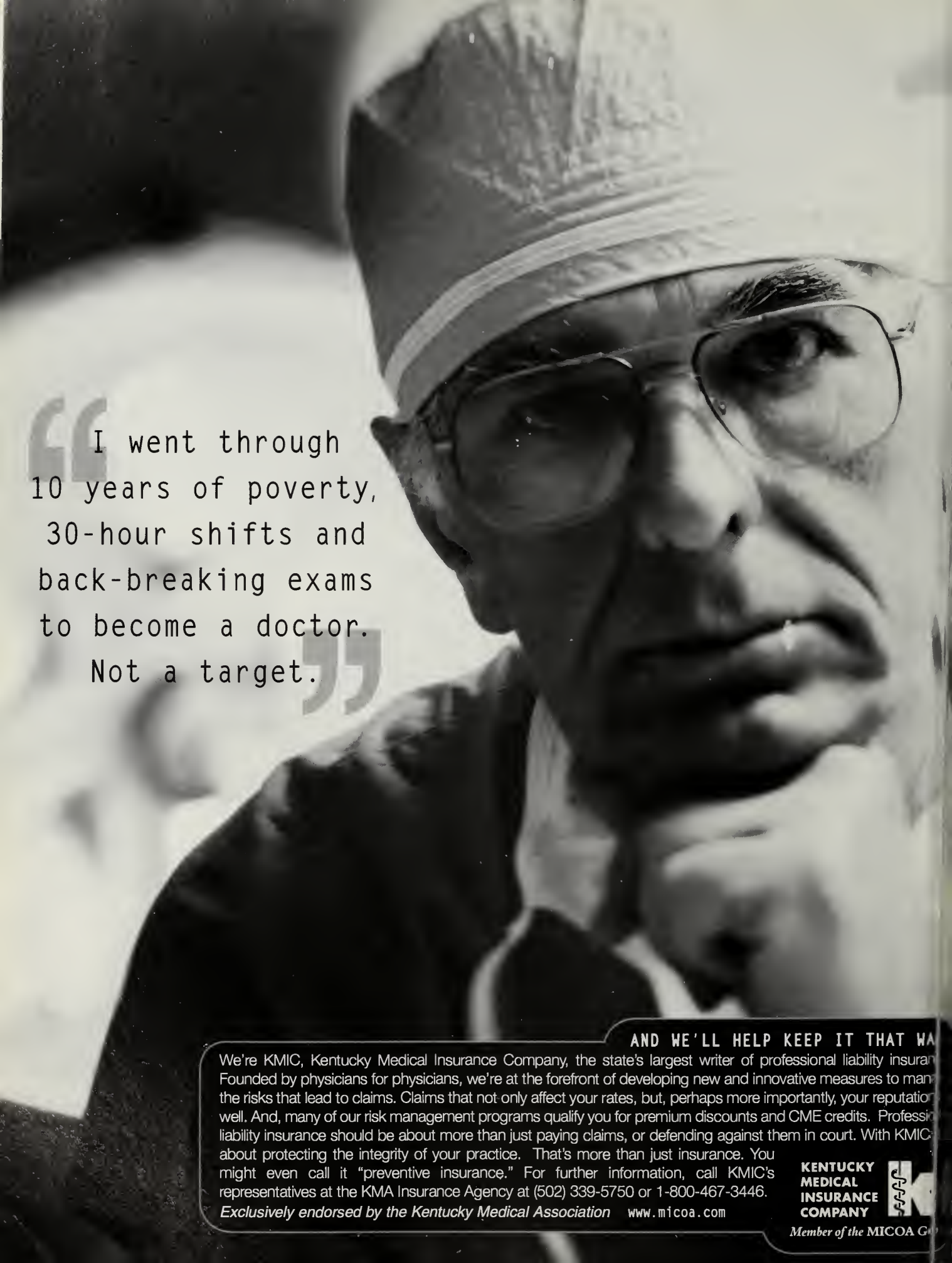
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Journal of the Kentucky Medical Association (ISSN 0023-0294) is published monthly under the direction of the Board of Trustees. Periodical postage paid at Louisville, KY and additional offices. Yearly subscription rates: \$35 domestic; \$45 foreign. Single issues \$4 per copy prepaid. POSTMASTER: Send address change to *Journal of the Kentucky Medical Association*, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222. Telephone 502/426-6200 Fax 502/426-6877

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Listed in *Index Medicus*. Printed on acid-free paper effective with Volume 87, Issue 4, 1989.

EDITORIAL AND ADVERTISING: Contact Sue Tharp, JKMA, The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222. Phone 502/426-6200; FAX 502/426-6877.

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Printed by the Ovid Bell Press, Inc, Fulton, Missouri 65251.

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Season's Greetings

This time of year thoughts turn towards "Peace on earth, good will towards men." It does not matter what your faith is—this time of reflection is useful to all. As we reflect on our life's work, truly it is "more blessed to give than receive." Who else gets the chance to deliver or restore a child to his or her parents—return a mother or father to their family?

This is a great and meaningful gift—but who is the giver and the receiver? Our patients give this great gift of allowing us to be part of their family's most cherished and trying moments. We must always strive to protect this gift and this relationship.

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MONITORING **Medicine**

NEWS FOR KENTUCKY PHYSICIANS

OIG WORKPLAN 2000

The Department of Health and Human Services (DHHS) in Washington is charged with overseeing the federal Medicare program. One branch of DHHS, known as the Office of Inspector General (OIG), investigates and audits whether federal laws and regulations are followed by participants in the Medicare program. Thus, the OIG investigates physicians and health care providers for alleged fraud and abuse.

Each year, the OIG publishes a "work plan" that details what it will be investigating in the area of fraud and abuse for a particular year. Set out below are those OIG initiatives that will be aimed at physicians during 1999-2000. The entire report can be obtained from the Department for Health and Human Services website at <http://www.dhhs.gov/progorg/oig/>.

Physician Involvement in Approving Home Health Care

This follow-up review will determine the current extent of physi-

cian involvement in approving and monitoring home care for Medicare beneficiaries. Earlier OIG work found that physicians often did not have a relationship with their home health patients and relied extensively on home health agencies to determine the care needed. As part of our review, we will look at how frequently physicians examine home care patients and identify obstacles to physician involvement in monitoring their patients.

Role of the Nursing Home Medical Director

We will examine how the role of the nursing home medical director has been interpreted and implemented and how the medical director affects quality of care. The Omnibus Budget Reconciliation Act of 1987 broadly requires nursing homes to designate a medical director to be responsible for implementation of resident care policies and coordination of medical care in the facilities. This review is one of a series on the quality of care in nursing homes.

MONITORING Medicine

Physician Routine Nursing Home Visits

This review will assess whether HCFA needs to establish controls over Medicare payments for routine nursing home visits. Currently, physicians bill one of three possible procedure codes, depending on the level of care, when providing services to nursing home residents. The HCFA allows payments for physicians' routine monthly examinations, in addition to other medically necessary services. Our analysis in five States revealed that physicians sometimes billed for more services than they could perform in a normal workday. In these States, Medicare paid over \$120 million for nursing home visits in FY 1998. Based on the level of care required for the codes billed, we have concerns about the quality of care provided to beneficiaries and the payments allowed for these services.

Physicians at Teaching Hospitals

This initiative is designed to verify compliance with Medicare rules governing payment for physician services provided in the teaching hospital setting and to ensure that claims accurately reflect the level of service provided to patients. Previous OIG work in this area suggested that many providers were not in compliance with applicable Medicare reimbursement policies.

Automated Encoding Systems for Billing

We will determine whether errors found in Medicare billings for physician services are associated with providers' use of automated encoding software. We will also examine billing processes to identify vulnerabilities that occur when physician offices bill independently or through use of a third party system.

Reassignment of Physician Benefits

We will evaluate the practice of allowing physicians to reassign their billing numbers to clinics. Clinics that employ more than one doctor may accept a reassignment of the physicians' billing numbers, thus allowing the clinic to handle all billing and keep all fees for services provided by the physicians, usually in exchange for paying a flat fee or salary to the physicians. This practice, known as reassignment of benefits, provides considerable convenience to both physicians and the clinic business offices. Typically, in these instances, the physician never sees what is billed under his or her physician number. This practice shifts the accountability and liability for billing abuses away from the physician to the clinics. We will examine past reassignment abuses to determine specific vulnerabilities.

Myocardial Perfusion Imaging

We will assess the medical appropriateness of myocardial perfusion imaging and explain the high increase in utilization since 1997. Myocardial perfusion imaging is a cardiac imaging procedure that is used to detect coronary artery disease and determine prognoses. This type of imaging procedure accounted for a large portion of the 23% increase in billing for all nuclear imaging services between 1997 and 1998.

Private Physician Contracting

This study will review the impact of private contracting between Medicare beneficiaries and physicians. Under the 1997 Balanced Budget Act, physicians and beneficiaries may enter into agreements specifying that the beneficiary will pay out-of-pocket for Medicare-covered services provided by that physician. Physicians who choose to provide covered services under these contracts must "opt out" of the Medicare program for 2 years. They may not receive payment from Medicare for any service regardless of whether it is provided on a fee-for-service or capitated basis. Though relatively few physicians have chosen this option, its impact on beneficiaries' access to care, as well as other beneficiary protections, is unclear.

MONITORING **Medicine**

Advance Beneficiary Notices

We will examine the use of advance notices to Medicare beneficiaries and their financial impact on beneficiaries and providers. Physicians must provide advance notices before they provide services that they know or believe Medicare does not consider medically necessary or that Medicare will not reimburse. Beneficiaries who are not notified before they receive such services are not responsible for payment. Indications are that practices vary widely regarding when advance beneficiary notices are provided, especially with respect to noncovered laboratory services.

Duplicate Payments for Office Visits to Nephrologists

This review will identify situations in which Medicare made separate payments to nephrologists for dialysis patients' office visits but the services were already included in the monthly capitation payment for physician services during the same period.

Physician Incentive Plans

We will review physician incentive plans included in contracts between physicians and managed care plans. In March 1996, HCFA published its final rule requiring managed care plans to disclose any arrangements that financially reward or penalize physicians based on utilization levels. It also requires plans to disclose these arrangements to beneficiaries. As part of this review, we will also look at other clauses in these contracts that may affect the quality of care provided.

Medicare Provider Numbers and Unique Physician Identification Numbers

We will determine whether information associated with Medicare provider numbers and unique physician identification numbers is accurate and up to date. A number of OIG reports have identified deficiencies in the issuance of provider numbers for specific areas of the program, such as durable medical equipment providers and independent physiological laboratories. Other studies have

noted that unused provider numbers are not deactivated timely and thus constitute a potential fraud vulnerability. In recent years, HCFA has taken a number of actions to standardize Medicare enrollment and has required providers to submit more information to ensure compliance with Social Security Act reporting requirements. We will assess the current condition of this information.

Medicare Part B

Medicare Part B helps pay for doctors' services, outpatient hospital care, diagnostic tests, durable medical equipment, ambulance services, and many other health services and supplies not covered by Medicare Part A. The most common Part B violation involves false provider claims to obtain payments. The OIG receives complaints from a variety of sources and conducts widespread investigations into fraudulent schemes in various areas of medical service. We will investigate a broad range of suspected fraud and present cases for both criminal and civil prosecution.

KMA News Review

Below are synopses of news items that have appeared recently in various publications regarding issues of interest to Kentucky physicians.

- Fewer physicians are reporting profits from capitation arrangements, according to a survey conducted by National Health Information, LLC. According to the survey, primary care capitation rates fell 9% over the past year; the average number of capitation arrangements fell significantly, although revenues from capitation increased, suggesting a consolidation rather than a retreat from such risk arrangements; and the number of physicians reporting profits from capitation declined from 42% to 34%. *[PR Newswire]*
- The Denver medical community is suffering from a rash of physician group failures around the city. Such groups, which commonly take the form of IPAs, have unexpectedly spent more money on medical services, especially drugs, than was allotted to them by managed care companies. The failures have had a dramatic impact on Denver's medical community where 54% of physicians have changed their office addresses in the past year and the number of primary care physicians has decreased by 5.2%. Such failures are also a problem in California where 90% of physician groups are on the brink of insolvency. *[Dallas Morning News]*
- Members of Illinois' largest HMO, HMO Illinois, can choose a chiropractor to coordinate health care under a new policy announced by the company. Chiropractors will be able to evaluate cold and flu symptoms and give routine physical exams, as well as decide what other care is necessary. *[Associated Press]*
- The Mount Auburn Cambridge IPA in Boston is backing away from a controversial plan to fine physician members of the IPA \$250 per day for each day a patient is hospitalized when it was determined that the hospitalization was not medically necessary. The plan was highly criticized by physicians and organized medicine. *[Associated Press]*
- Federal legislation that would allow physicians to bargain collectively has been "shelved" by House Judiciary Chairman Henry Hyde (R-IL) after being asked to do so by House Speaker Dennis Hastert (R-IL). Hyde said he plans to proceed with action on the bill next year. *[Reuters]*
- A class action suit was filed against Aetna in San Francisco claiming that the company misled customers by not disclosing that physicians may have a financial incentive to withhold care. The suit is being led by trial lawyers who won millions in cases against the tobacco industry. *[San Francisco Chronicle]*
- A lawsuit filed in Miami, Florida accused Humana of failing to tell its members that decisions on whether to cover their medical treatment would be influenced by financial incentives to physicians and claims reviewers. The lawsuit alleged that cash bonuses were paid to claim reviewers, and that physicians received payments designed to reduce the number of patient claims that would be approved. *[Courier-Journal]*

IN MEMORIAM

*By medicine life may be prolong'd
yet death
Will seize the doctor too.*

— Shakespeare

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Louisville

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Covington

John M. Allen MD
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Paul Atkins MD
Floyds Knobs

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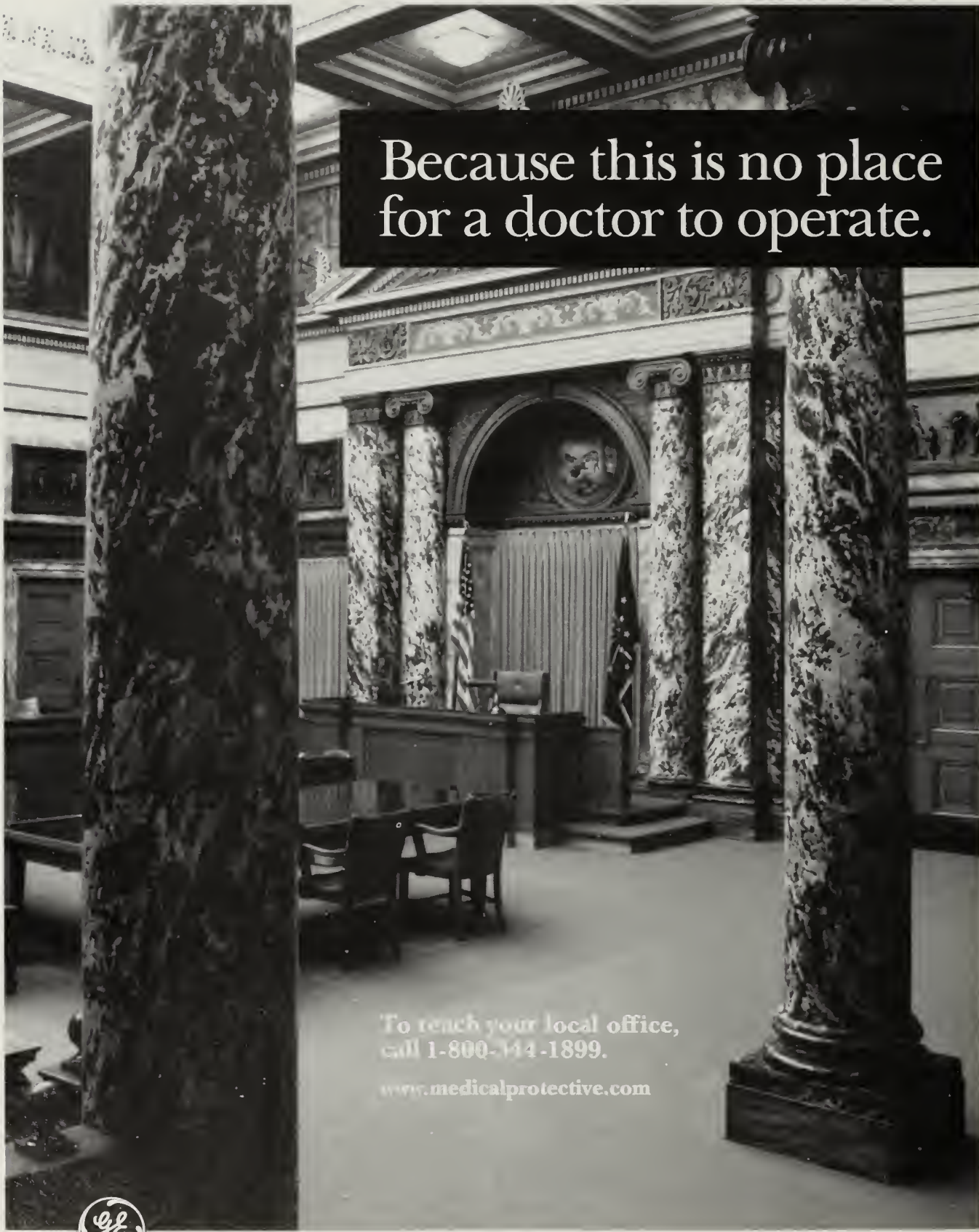
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MANAGEMENT OF INCIDENTALLY DISCOVERED CERVICAL PARAGANGLIOMAS: REPORT OF TWO CASES AND REVIEW OF CURRENT ISSUES

Eric L. Grogan, MD; William G. Wheeler, II, MD; Charles B. Ross, MD

Paragangliomas of the head and neck are uncommon neoplasms arising from the extra-adrenal paraganglia and include carotid body and glomus vagale tumors. These lesions may be discovered incidentally by imaging studies performed to evaluate carotid atherosclerotic occlusive disease. Incidental paragangliomas of the head and neck may be smaller than those discovered due to symptoms. Although surgical resection remains the definitive treatment for head and neck paragangliomas, important issues of management arise when such lesions are discovered. Two recent cases are reported. Epidemiology, pathophysiology, diagnostic evaluation, and issues of management of head and neck paragangliomas are discussed.

Paragangliomas of the head and neck are uncommon neoplasms that arise from the extra-adrenal paraganglia. Carotid body tumors (chemodectoma) are most common among head and neck paraganglioma with jugulotympanic and vagal (glomus vagale) tumors less frequently encountered.¹ The clinical presentation of these tumors is variable. The most common presenting symptom reported in previous series has been a painless mass in the neck; however, other reported symptoms include pharyngeal discomfort or fullness, otalgia, change in voice, and a variety of cranial nerve palsies depending on tumor size and location.²⁻⁵ In rare cases, cervical paraganglioma may exhibit neuroendocrine hypersecretory activity manifested by hypertension.⁶

There has been at least one reported case in the literature in which transient ischemic attacks

were attributed to the presence of bilateral carotid body tumors.⁷ However, carotid body tumors and other paraganglioma may be discovered incidentally by imaging studies performed to evaluate carotid atherosclerotic occlusive disease as a cause for transient ischemic attacks or asymptomatic carotid bruits.^{3,8} Westerband et al³ have shown that tumors discovered incidentally are generally smaller than those which are brought to medical attention because of mass or other symptoms. Important issues of management may arise in this clinical circumstance and are illustrated by the following cases and discussion.

Case 1

L.P., a 45-year-old white female presented to the hospital emergency department following a 20 minute episode of left arm paresthesias and weakness which alarmingly occurred as she was driving an automobile. She likewise reported several weeks of intermittent tinnitus and facial paresthesias. An unenhanced CT scan of the head was normal. She was systemically anticoagulated with heparin and admitted to the neurology service with the diagnosis of right carotid distribution transient ischemic attack. Diagnostic studies, including the following, were obtained. Transthoracic echocardiography was normal. Arch aortography with

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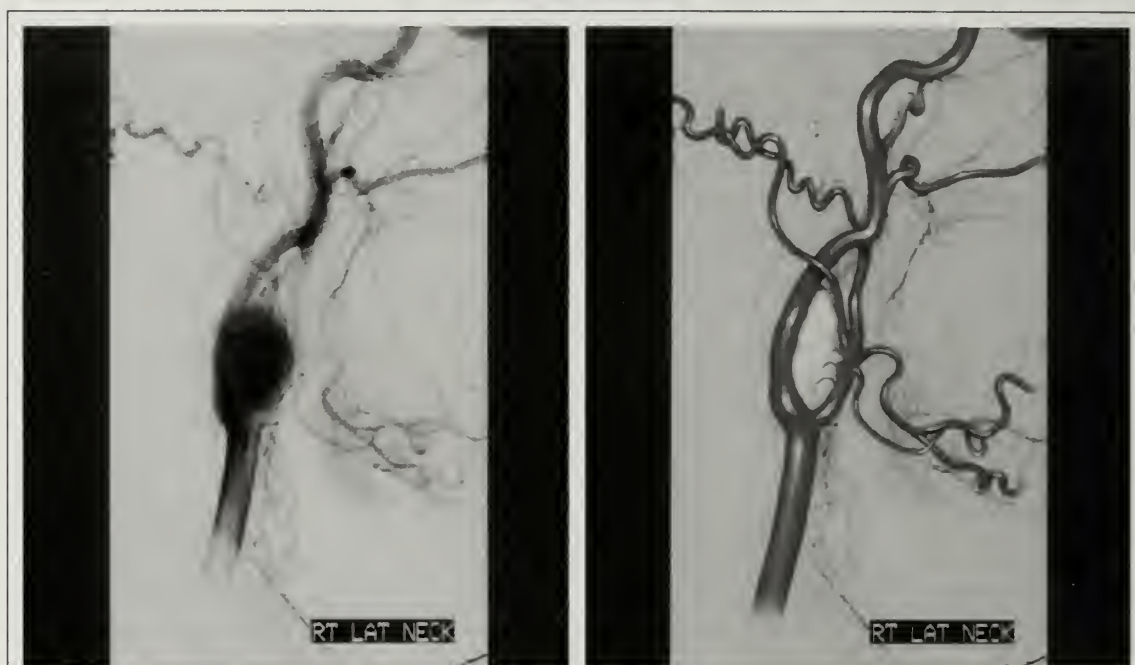


Figure 1. Selective right carotid angiogram and enhanced illustrated image demonstrating carotid body tumor from case 1. The vascular lesion is positioned within the carotid bifurcation. Because this lesion was relatively small, the bifurcation is only mildly "splayed."

bilateral selective carotid and vertebral angiography showed no intraluminal arterial pathology but did demonstrate a 2.5 cm × 2.0 cm vascular mass arising at the carotid bifurcation between the internal and external carotid arteries, consistent with a carotid body tumor (Figure 1).

The patient's past medical history was negative for neck discomfort, palpable mass, hypertension, or flushing episodes. Her family history was negative for neck tumors and adrenal tumors. Physical examination revealed no palpable neck masses or bruits by auscultation. Resection was advised and scheduled electively. Aspirin, 325 mg daily, was initiated.

One month later, the patient was admitted for surgery. A continuous infusion of low molecular weight dextran was initiated. Intraoperative EEG monitoring was started prior to the induction of general anesthesia and continued throughout the procedure. The tumor and carotid bifurcation were exposed utilizing technique standard for carotid endarterectomy. The vagus and hypoglossal nerves were identified and protected. The digastric muscle was mobilized and retracted superiorly, but its tendon did not require division. Before beginning actual manipulation of the carotid arteries or tumor,

the patient was systemically anticoagulated with heparin. The tumor filled the space between the internal and external carotid arteries but related most to the external carotid artery. Periadventitial dissection with a 15 blade scalpel was used to completely resect the tumor without the requirement for temporary cessation of flow through either the internal or external carotid arteries. Prominent lymph nodes along the jugular vein were resected and sent to pathology with the tumor. Heparin was not reversed.

Pathology showed a 3.5 cm × 1.5 cm × 2.0 cm carotid body paraganglioma without evidence for lymph node metastasis. Recovery was uneventful. The patient has not experienced recurrent transient ischemic episodes nor any sign of local recurrence at 21 months of followup.

Case 2

A 74-year-old white male presented to his internist following a 20 minute episode of near-syncope with slurring of speech and confusion. He had had previous aortic valve replacement and was chronically anticoagulated with warfarin. Echocardiography showed no valvular vegetations, and dobutamine-stress echocar-

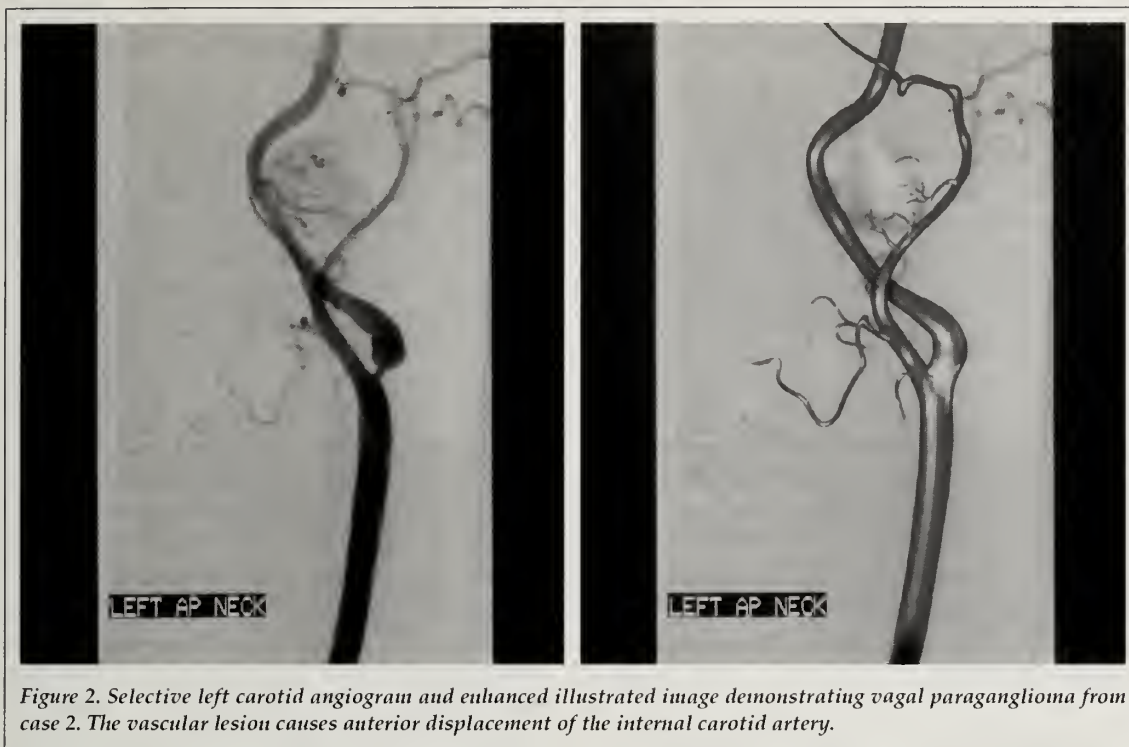


Figure 2. Selective left carotid angiogram and enhanced illustrated image demonstrating vagal paraganglioma from case 2. The vascular lesion causes anterior displacement of the internal carotid artery.

diography was negative for inducible myocardial ischemia. Carotid duplex ultrasonography demonstrated atherosclerotic plaque of mixed composition causing a stenosis estimated between 50% and 69% in severity (Peak systolic velocity 258 cm/sec and peak end-diastolic velocity 72 cm/sec).

The patient was an active individual. His past history was remarkable for uncomplicated aortic valve replacement, hypercholesterolemia, and mild chronic renal insufficiency (serum creatinine 1.6 mg/dl). He was a previous user of tobacco at 90 pack years but had stopped smoking 13 years earlier. He had no history of hypertension. Physical findings were remarkable for normal carotid pulses with bilateral bruits. A valvular murmur was present, and there were bilateral femoral bruits. No cranial nerve deficits or neck masses were noted.

Vascular surgical consultation was obtained and angiography recommended. A 60% stenosis was noted at the origin of the left internal carotid artery. An enhancing mass was incidentally noted posterior and superior to the carotid bifurcation supplied by arterial branches arising from the external carotid artery and subtly displacing the internal carotid artery ante-

riorly (Figure 2). This lesion appeared to be a vagal paraganglioma. Other abnormalities included a moderate left vertebral stenosis and mild, nonstenotic right carotid bulb atherosclerotic disease.

Left carotid endarterectomy was recommended, and the patient was electively admitted to the hospital. Standard carotid endarterectomy protocol including the addition of preoperative aspirin therapy, intraoperative low-molecular weight dextran infusion, and continuous intraoperative EEG monitoring were utilized.

After initial exposure of the carotid bifurcation, attention was turned posteriorly and superiorly. The hypoglossal nerve was mobilized. The digastric muscle was mobilized and retracted superiorly. The glossopharyngeal nerve was identified. The vagus nerve was identified and traced superiorly until a rounded, smooth, gray intravagal tumor was exposed. Arterial blood supply to the tumor was ligated and divided. The tumor was resected with preservation of the main portion of the vagus nerve. Pathology demonstrated a 2.0 cm \times 1.3 cm \times 2.6 cm paraganglioma.

The patient was anticoagulated with heparin following tumor resection. A standard

endarterectomy and closure with patch was performed. The patient awoke promptly from the procedure. Anticoagulation with warfarin was reestablished. Pathology revealed focal hemorrhagic necrosis and ulceration in the carotid plaque. The patient experienced difficulty swallowing, which resolved over the course of 6 weeks. He also experienced hoarseness and weakness of his voice which resolved between 10 and 12 months following the procedure. At 18 months, he has had no further episodes of transient ischemic attacks and has no evidence for tumor recurrence. Octreotide scintigraphy was performed at 12 months postop and demonstrated no areas of uptake suspicious for additional paragangliomas or metastatic lesions.

DISCUSSION

Carotid body tumors and other head and neck paragangliomas are rare neoplastic lesions with an incidence of 0.012% reported in one series of surgical pathology specimens registered at one referral institution.⁹ Reported series of cases generally include less than 40 patients collected over intervals of at least 10 or more years, and most patients in these series have presented with the classic complaint of a painless neck mass.^{2-4,10} However, in the 1998 report by Westerland et al³ the presence of a carotid body tumor was identified in eight patients as an incidental finding during imaging procedures obtained to evaluate carotid occlusive disease. These patients had tumors that were statistically significantly smaller in size than the tumors present in patients who had presented with complaints of a neck mass, ie 2.7 ± 1.0 cm versus 4.3 ± 1.7 cm, respectively.

Increasing public awareness of the role of carotid atherosclerotic disease in the pathogenesis of stroke and subsequent increases in the use of sophisticated imaging modalities to evaluate such patients may make the incidental finding of relatively small head and neck paragangliomas, as in the two cases presented herein, a more common clinical circumstance deserving further discussion.

Paragangliomas can arise in sporadic or familial forms. Most patients in reported series have presented in their fourth or fifth decades. No sex predilection has been consistently identified for familial cases, but recent series have reported a predilection for females in sporadic cases.^{1,2} Grufferman et al¹¹ reviewed reported series and noted that 10% of cervical paragangliomas were familial. Multicentricity, including bilaterality, may occur in 2% to 10% of sporadic cases and 25% to 50% or even higher in familial cases.^{1,5,11} Familial inheritance occurs in an autosomal dominant pattern modified by genomic imprinting, ie, the gene is passed in a Mendelian manner with phenotypic expression determined by the sex of the parent. Children of female carriers will not develop tumors but 50% will carry the gene. Children of male carriers have a 50% chance of developing tumors. A gene may be silently passed from female to female thus complicating the diagnosis of familial paraganglioma.¹ Although definitive work remains to be done, the responsible gene appears to be the long arm of chromosome 11. Two distinct sites have been mapped in two separate kindred.¹² This work may facilitate the development of a genetic screening test in the future.

The potential for a familial pattern of inheritance and the increased incidence of multicentricity in familial versus sporadic cases clearly emphasizes the importance of a careful family history when a patient with a head and neck paraganglioma is encountered. Questions should attempt to uncover previous relatives who may have had head and neck masses or operations for removal of head and neck tumors of unknown type as well as kindred who may have had "severe high blood pressure" or adrenal tumors (pheochromocytomas).

As of 1996, Ikejiri et al⁶ could identify only 11 cases of "functional" carotid body tumors without other coexistent extra-adrenal paragangliomas or adrenal pheochromocytomas in the world literature, and they reported one new case. This phenomenon is reported with slightly higher frequency in association with other cervical paraganglioma but is still rare.¹³ Neuroendocrine hypersecretory activity may be

manifested by hypertension, flushing, cardiac palpitations, cardiac dysrhythmias, headaches, dizziness, and episodes of diaphoresis, and is almost always observed in patients who have other coexisting paraganglioma and or adrenal pheochromocytoma.^{14,15} Patients who have suggestive symptoms, bilateral tumors, or a positive family history for paragangliomas should have a 24 hour screen for vanillylmandelic acid (VMA) and metanephrine. Octreotide scintigraphy should also be considered.¹⁶

Selective carotid angiography has been the standard for localization of carotid body tumors in the past and is still recommended. Angiography is useful for diagnosis, evaluation of collateral cerebral vascularization, and also offers the potential for adjunctive preoperative embolization in the case of large tumors. Carotid body tumors can be distinguished from cervical vagal paragangliomas using angiography by noting the displacement of the carotid vessels. Vagal tumors are more cephalad and do not typically increase the angle between the internal and external carotid arteries. Vagal tumors may cause anterior displacement of the internal carotid artery as noted in our case (Figure 2). Both contrast computer tomography (CT) and magnetic resonance imaging (MRI) readily demonstrate paragangliomas and are useful in evaluating the relationship of these lesions to surrounding structures and the skull base. Because CT angiography and magnetic resonance angiography are noninvasive, these modalities may soon replace conventional angiography as the preferred imaging modalities for cervical paragangliomas.³ McCaffrey et al¹⁷ recommend MRI for screening the kindred of patients with familial paraganglioma. Octreotide scintigraphy is a relatively new nuclear medicine study that can provide information on paragangliomas in the whole body and can be useful in detecting multicentricity and/or metastasis.¹⁶

Westerband et al³ and others^{8,18,19} have reported the diagnosis of carotid body tumors by color flow duplex ultrasonography (CDU). Characteristic features of carotid body tumors on CDU include the presence of a solid, hypo-

echoic, highly vascularized mass located between the internal and external carotid arteries. The mass may "splay" or widen the space between the internal and external carotid arteries. Doppler frequency sampling may produce a turbulent, low-resistance arterial flow pattern.¹⁸ CDU may be useful as a screening test for familial cases as well as an inexpensive, noninvasive method for following carotid body tumors being managed by clinical observation as opposed to resection.^{3,18}

The incidence of malignancy for carotid body tumors and other cervical paragangliomas is generally less than 5%, although it has been reported as high as 19% for vagal paragangliomas.^{1,20} Malignancy can only be defined by the presence of metastasis with the most common spread being to regional lymph nodes, although distant spread to bone, lung, liver, and other sites have been reported.¹ No definitive studies correlating tumor size with malignancy have been reported, but Netterville et al⁵ reviewing 46 tumors in 30 patients only found metastasis in association with tumors 8 cm or greater in size.

The natural history of paragangliomas is variable and complicates treatment recommendations. These tumors usually present in the fourth or fifth decades of life and may remain stable in size for many years. One group has recorded growth rates of 0.5 cm per year.²¹ However, sudden size increases and recurrence with incomplete excision have been reported,¹ and the Mayo Clinic group has noted nearly 75% of patients will eventually develop symptoms.² As tumors increase in size, local symptoms and cranial nerve deficits become more common. No clinical or histologic features are known which may predict the rate at which any individual tumor may grow.¹

The treatment of carotid body tumors and other cervical paragangliomas should be individualized with consideration given to many factors such as age of patient, location of tumor including ease of resectability, rate of growth of tumors being serially observed, family history, bilaterality, and rare malignant potential. Surgical resection, radiation therapy, and obser-

vation represent treatment options with surgical resection being the only modality considered curative.¹⁻⁴ As noted in the recent review by Netterville,¹ the value of radiotherapy is controversial, with both tumor regression as well as early recurrence following apparently successful treatment noted.

In historic series, the incidence of significant bleeding, stroke, and even death complicating resection of carotid body tumors has been high, but the rate of perioperative morbidity and mortality has fallen quite favorably over the past 10 years.^{2,4} Contemporary series report combined stroke-death rates between 2.7% and 6%.²⁻⁵ Surgical experience and familiarity with high-cervical and skull base exposures, loupe magnification, use of modern vascular technique, bi-polar electrocautery, and preoperative transcatheter embolization of the feeder arteries in tumors greater than 5 cm in size represent technical advances which have contributed to improved outcomes. In contemporary practice, the risk of a central neurologic injury should be less than 5% for most carotid body tumor resections utilizing the technical principles noted above.^{1,2}

Given the possibility that smaller, asymptomatic lesions may be encountered with increasing frequency in contemporary clinical practice, the dilemma of surgical resection versus serial observation should be considered. Although considered curative, surgical resection of carotid body tumors and other cervical paragangliomas carries the associated risk of new cranial nerve deficits and/or Horner's syndrome in 16%⁴ to 40%² of patients. Preoperative transcatheter embolization has been reported as a helpful adjunct in reducing blood loss complicating removal of large tumors but is controversial due to the inherent risk of stroke as a complication. Westerband et al³ reported that an ipsilateral stroke occurred in one out of 6 patients in whom this technique was used and recommended that its selective use be limited to tumors greater than 5 cm in size.

Shamblin et al²² have reported that tumor size is directly related to neurovascular complications associated with surgical therapy. Similar

experience has been reported by Westerband et al,³ McCaffrey et al¹⁷, and Netterville et al.⁵ Increased ease of resectability with diminished potential for complications in the setting of unpredictable rate of growth and malignant potential represents the most cogent argument for surgical resection of relatively small, asymptomatic cervical paragangliomas. When operative intervention is elected for carotid body tumors, the use of modern vascular technique and potential availability for any number of vascular reconstructive options is mandatory. Because the demands of high cervical exposure combined with the need for vascular reconstruction can be technically challenging, the Vanderbilt group has advocated a two-team, ENT and vascular surgical, approach.¹

Many authors have reported observation of small carotid body tumors and other cervical paraganglioma utilizing imaging modalities discussed above.^{1,3,18} In the clinical setting of asymptomatic lesions of small size in patients with advanced age, high operative risk, or bilateral tumors in which removal of both lesions could trigger baroreflex failure^{1,5,23} or devastating bilateral cranial nerve deficits, observation with the use of serial imaging studies cannot be criticized. In the case of our patient who had the intravagal paraganglioma, resection was undertaken because operation in the same region was going to be done anyway and because the lesion was amenable to resection without compromising the vascular procedure or substantially increasing the length of time under general anesthesia. We additionally reasoned that potential resection at a later date could be more hazardous due to scar formation in the region of the carotid sheath. However, given our patient's age of 74 years, serial observation by MRI scanning following the carotid endarterectomy was a viable option.

In summary, carotid body tumors and other cervical paragangliomas are uncommon lesions which may be encountered incidentally during evaluation of patients for carotid atherosclerotic disease. Because such tumors are unlikely to be malignant and yet likely to be asymptomatic and small in size relative to tumors reported in

historic clinical series, issues of management may be more complex with options more plentiful. Surgical treatment remains the most definitive mode of therapy, but in a variety of clinical circumstances, observation utilizing serial imaging modalities may be considered.

ACKNOWLEDGMENTS: The authors express appreciation to Dr James L. Netterville, Department of Otolaryngology, Vanderbilt University Medical Center, Nashville, Tennessee, for his review of the manuscript and suggestions, and to Mr Kevin Burns and Mr Dominic Doyle of Vanderbilt Medical Art Group for their helpful illustrations.

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Daniel W. Varga, MD

PATIENT'S RIGHTS

As the debate in Congress has progressed on the Patient's Bill of Rights, there have been obvious comparisons to the constitutional Bill of Rights. Both the bill presented this year in Congress and the Bill of Rights are thoughtful articulations. However, the fundamental assumptions upon which these bills rest are vastly different, and one need only look to the Declaration of Independence to discern these differences.

In the first paragraph of the Declaration, the colonial representatives announce their intention to sever the political bonds tying them to England for the purpose of assuming "among the powers of the earth, the separate and equal station to which the Laws of Nature and of Nature's God entitle them." The second paragraph begins with the enumeration of "self-evident" rights. In the first instance, there is an assumption of responsibility for the administration of government; in the second, an assertion that common understanding embraces life, liberty, and certain other pursuits as unalienable. These tenets formed the basis for a violent Revolution and the subsequent establishment of limited, representative institutions constrained by delineated rights reserved to the individual. By comparison, the Patient's Bill

of Rights legislation is lacking in a basic understanding of these two principles. Is access to health care an immutable, commonly understood "right"? Who is assuming responsibility for the health of the populace? Is it the Government? Is it the employers? The insurers? The physician? The patient? It is perhaps not too surprising that this legislation has incited vast differences of opinion given the basic unanswered questions upon which it relies for a fundamental understanding of the issues involved.

In Jefferson's Declaration, there follows an exhaustive chronicle of the injustices perpetrated by the Crown. Many read like grievances voiced by patients and physicians against insurers and government agencies:

"He has called together . . . bodies at places unusual, uncomfortable and distant from the repository of their public Records, for the sole purpose of fatiguing them into compliance with his measures." (Read unilateral denial, automatic downcoding, and documentation requirements).

"He has dissolved Representative Houses repeatedly, for opposing with manly firmness

As the colonists had obvious reasons for seeking remedy for the wrongs inflicted by the Crown, so too do patients and their physicians have obvious reasons for seeking to resolve much of the idiocy of the current health care system.

his invasions on the rights of the people." (Read unilateral deselecting of physician groups).

"He has made Judges dependent on his Will alone, for the tenure of their offices, and the amount and payment of their salaries." (Read review companies paid by the number of denials or downcodes, insurance company employees empowered to determine medical necessity).

"He has erected a multitude of New Offices, and sent hither swarms of Officers to harass our people, and eat out their substance." (Read every piece of hassle built into the current system).

"For imposing taxes without our consent." (Read provider tax).

As the colonists had obvious reasons for seeking remedy for

If a Patient's Bill of Rights is to be truly successful, it will first require that patients, physicians, and any other party concerned similarly declare their understanding of and commitment to a similar set of beliefs.

the wrongs inflicted by the Crown, so too do patients and their physicians have obvious reasons for seeking to resolve much of the idiocy of the current health care system. Again however, the question of responsibility arises. His Majesty's Government was the clear executor of the colonists' misfortune, but in the current health care environment the assignment of blame and ability to redress grievances is less clear. Do patients demand too much and, if so, should they be restrained? If so, who should restrain them? Are physicians regular perpetrators of fraud and selfishly loose with medical necessity or are they

devoted patient and societal advocates? Are employers dedicated to the well being of their workforce or are they dedicated solely to the shareholder bottom line? Are insurers profligate profiteers or simply actuarial stewards of health related risk? Is the government a concerned and benevolent arbiter of issues relating to its citizens' health or an intrusive, obstructive bureaucracy? Again, while physicians have strong opinions regarding the above questions, society as a whole seems far from consensus on them. This lack of consensus makes their resolution next to impossible.

The Declaration proceeds to affirm that the people have voiced their complaint through the proper channels, on multiple occasions, without any evidence of redress. It then declares the independence of the colonies and abolishes any allegiance to the Crown, enumerates the powers now retained by the Colonies, and (most importantly) finally, "for the support of this Declaration," pledges "to each other our Lives, our Fortunes and our Sacred Honor." Ultimately, the Constitution of the United States

of America and its Bill of Rights works because of the principles outlined in the Declaration. The Declaration acknowledges an assumption of responsibility by the drafters, affirms the commonly held beliefs that underpin their decision making, clearly articulates the wrongs done and the perpetrators thereof, and in the end commits everyone involved to a course of action which is risky, costly, and decisive. This commitment will energize and sustain a revolution and guide and temper the formative deliberations of an embryonic government. If a Patient's Bill of Rights is to be truly successful, it will first require that patients, physicians, and any other party concerned similarly declare their understanding of and commitment to a similar set of beliefs. As a society, our understanding of these beliefs is nebulous and our commitment to them tenuous. Until we concede the need to understand and commit to such beliefs, whatever they may ultimately be, we are ill advised to codify "rights" based upon them.

Daniel W. Varga, MD



Season's Greetings!

The American Medical Association Foundation appreciates the support of the Kentucky Medical Association and the Kentucky Medical Association Alliance. The AMA Foundation has fostered excellence in Medical Education, Research and Service since 1950. We wish you and your family a wonderful Holiday Season and a very Happy New Year in the year 2000.

Jack and Vicky Borders, Ashland

Tom and Nancy Bunnell, Edgewood

Jim and Jan Crase, Somerset

Gil and Carolyn Daley, Hazard

Uday and Aroona Dave, Madisonville

Brett and Mimi Davis, Owensboro

Bob and Angie DeWeese, Louisville

Dick and Beryl Dodds, Madisonville

Carl and Mary Evans, Lexington

Bob and Carol Goodin, Louisville

Wally and Gerry Montgomery, Paducah

Don and Faye Neel, Owensboro

Preston and Lucille Nunnolley, Lexington

Don and Nancy Swikert, Union

Louis and Marla Vieillard, Russell



The Kentucky Medical Association Alliance thanks the Kentucky Medical Association for your support during the 1999 year. Thank you to all Kentucky medical families for your dedication and service to your communities, and for your friendship this year. The Alliance wishes you a joyous holiday season and a very happy new year.

Carolyn B. Daley
KMAA President



149th KMA Annual Meeting

Top left, Harry W. Carloss, MD, Paducah, took the President's Inaugural Oath, as administered by Board Chair J. Gregory Cooper, MD, Cynthiana. Top right, President Carloss addressed the Wednesday night House of Delegates. Bottom, the outgoing President and First Lady, Don and Sonia Stephens, welcomed the newly inaugurated President and First Lady, Harry and Barbara Carloss.





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Top left, President Carloss was joined by his immediate officers, l to r, President-Elect Dr Bill VonderHaar and Vice President Dr Andrew Pulito. Right, newly installed President Carloss presented the Past President's plaque to Dr Stephens. Center left, AMA President-Elect Dr Randolph Smoak, addressed the House of Delegates. Right, Past President Stephens and his wife Sonia were joined by KMA Executive Vice President Bill Applegate. Bottom, President-Elect VonderHaar was escorted to the podium by Past Presidents Dr Ken Peters and Dr Robert Goodin (not pictured).



Top: Dr Carloss and his wife Barbara were pleased to have their children join them on this very special day. Pictured left to right are son Andy, daughter Beth and daughter Caroline. Andy and Caroline are students and members of the national Honor Society, and Beth is a medical student at the University of Louisville. Bottom, Hiram C. Polk, MD, esteemed Professor and Chair of the Department of Surgery at the University of Louisville, addressed the Monday House of Delegates following his announcement as KMA's Educational Achievement Award honoree. President Stephens was pleased to make the presentation.

Inauguration

Harry W. Carloss, MD, a Paducah internist/oncologist, was inaugurated 1999-2000 President of KMA at the 149th Annual Meeting held in Lexington, September 27-30. A 1975 graduate of the University of Louisville School of Medicine, Dr Carloss served 13 years as a Delegate for the 1st District; 5 years as a Trustee; one term as Vice Chair and two terms as Chair of the Board of Trustees; and as Vice President prior to being named President-Elect. Current commitments include service on the following committees: Cancer, Committee on National Legislative Activities, Physician Advisory Committee to Health Kentucky, Professional Liability Insurance, Public Education, Scientific Program, and Legislative Quick Action.

Dr Carloss is a fellow of the American College of Physicians



and the Royal Society of Medicine. He is an Associate Clinical Professor of Medicine at the University of Louisville and an Assistant Professor of Internal Medicine at the University of Kentucky. He is deeply committed and devotes many hours to cancer research, cancer treatment, and Hospice endeavors.

Board of Trustees — Elections

The KMA Board of Trustees held its reorganizational meeting for the 1999-2000 Association year on September 30. Acting Chair William P. VonderHaar, MD, introduced the newly elected members of the Board and the new officers. William P. VonderHaar, MD, Louisville, has been named President-Elect, Andrew R. Pulito, MD, Lexington, was elected Vice President; Linda H. Gleis, MD, Louisville, was elected Secretary-



Top, l to r, KMA Past Presidents Donald C. Barton, MD, Corbin, and Richard F. Hench, MD, Lexington, were honored at a special Board Dinner held during the Annual Meeting. For their many years of dedicated service to KMA, filling too many positions to list here, their portraits will hang with those of other esteemed servants in the Board Room area of the KMA headquarters office. AMA President-Elect Randolph Smoak, MD, addressed the group gathered for this auspicious occasion. Bottom, KMA's most prestigious honor, the Distinguished Service Award, was bestowed upon Ardis Hoven, MD, Lexington. She was honored not only for her numerous contributions to the profession but also to her community. Awards Chair Richard F. Hench, MD, also of Lexington, was honored to make the presentation to his friend and colleague.



Alliance Past President Jan Crase presented AMA Foundation checks to Kentucky medical schools. Accepting were, top, Laura Schweitzer, PhD, Associate Dean of Faculty Affairs and Student Affairs at the UofL School of Medicine, and right, UK College of Medicine Dean Emery Wilson, MD. Bottom, l to r, FCMS President Andrew Moore, MD, and W. Porter Mayo, MD, Lexington, accepted a special KMA award commemorating the 200th Anniversary of the Fayette County Medical Society. House Speaker John W. McClellan, MD, made the presentation.



Treasurer. Newly elected Trustees were Donald R. Neel, MD, Owensboro, 2nd District, and James F. Beattie, MD, Bowling Green, 6th District.

The Board elected the Executive Committee members to serve with the President, President-Elect, Vice President, and Secretary-Treasurer for the

1999-2000 KMA year. Donald R. Neel, MD, Owensboro, was elected Chair, Board of Trustees, and Meredith J. Evans, MD, Middlesboro, was elected Vice Chair of the Board. Kenneth R. Hauswald, MD, Ashland, and Thomas E. Bunnell, MD, Crestview Hills, will continue as Trustees-at-large.

The next meeting of the Board was scheduled for November 17-18, 1999.

Five physicians were elected by the House of Delegates to serve on the 2000 Nominating Committee. Members elected were: P. Bruce Barton, MD, Corbin, Chair W. Lisle Dalton, MD, Lexington James P. Farrell, MD, Crestview Hills Linda Mumford, MD, Owensboro Jeffrey B. Richardson, MD, Elizabethtown

President's Luncheon

The President's Luncheon guests honored outgoing President Donald R. Stephens, MD, and witnessed the installation of Harry W. Carloss, MD, as the 149th President of KMA.

Dr Carloss's Inaugural Address focused on patients' rights, physicians' continuing role as guardians of healthcare, legislative efforts, and adapting to change and the use of technology. Notable comments included:

"We should work to break monopoly or monopsony power of insurance carriers. Physicians, not insurance companies, should determine medical necessity. . . . We should continue our role as guardians of public health and



safety. . . . Our future as physicians and our patients' health is tied to our legislative efforts. . . . We of the KMA must use change and technology as a positive force to enhance communications, organization, and participation.

We must lead the nation in adapting technology to preserve the health of our patients and the future of our profession."

Dr Carloss's address is printed in its entirety in the October 1999 *Journal*.



Top, left, Past President Ken Peters, MD, drew the winning ticket for two roundtrip airline tickets to anywhere in the continental USA or a free year of AMA membership, which was sponsored by KMIC. Right photo, Past President Danny Clark, MD, left, and Dennis Johnson, right, represented KMIC as Dr Peters presented the prize to the winner, 4th District Trustee Eugene Shively, MD. Center, AMA President-Elect Randolph Smoak, MD, listened attentively to reference committee discussion. Bottom, AMA Delegate Don Swikert, MD, Fayette County Delegate David Stevens, MD, and 10th District Trustee Andrew Pulito, MD, had a lively discussion during a break in House of Delegates action.



Top, r to l, Dr Burns Brady, Medical Director of Kentucky Physicians Health Foundation, enjoyed working in the Annual Meeting booth with Barbara Cox and Dr Robert Middleton, two of the Foundation's committee members. Bottom, l to r, Perry County Delegates Mitchell Wicker, MD, and Gil Daley, MD, smiled for the camera as they relaxed during a break.

DSA Award

Each year the Kentucky Medical Association presents the Association's highest award to a member who has served their community, their state, and their profession with honor.

The 1999 recipient of the Association's most prestigious honor, the Distinguished Service Award, was bestowed upon Ardis D. Hoven, MD, a Lexington infectious disease specialist. She was honored at the President's Luncheon not only for her contributions to the profession but also to her community.

In presenting the award to Dr Hoven, Awards Chair Richard F. Hench, MD, of Lexington included these comments:

"Dr Hoven has been a mainstay in the battle against HIV and AIDS and has consistently advo-

cated physician and public support for the dignity and right of all patients to have access to quality medical care. In addition, she has been at the forefront in proposing legislation and advocating laws and regulations dealing with family violence.

Perhaps her finest but most difficult hour was the period of 1993-94 when she was elected to lead this Association—the first woman president elected to the KMA's highest office. Maybe it was fate—maybe bad luck—or maybe the men just thought it was a good time to step back and let the women lead. Those were dark days for patients and physicians. Governor Jones and the General Assembly almost turned Kentucky's health care system upside down. They nearly succeeded. Despite the pressure and power of the Governor's

office and General Assembly leadership, Dr Hoven never faltered in her opposition to the massive bureaucracy of House Bill 250. Almost on a daily basis she was either testifying—button holing legislators in the halls—or telling the Governor and his staff NO. Following that eventful Session, KMA leadership and staff developed a respect for Ardis Hoven rarely accorded a KMA leader.

But Dr Hoven didn't quit. She understood politics and recognized that the only way to reverse HB 250, Medicaid cuts, and the tax was through the legislature or the courts. She immediately convened a meeting with staff to draft plans to repeal the provider tax, restore Medicaid funding, and amend major portions of House Bill 250. Dr Hoven recognized that the first obstacle to success was educating a KMA membership





that had been rather complacent during the 1994 Session, confident that the General Assembly would reject Jones' proposals. In the summer of 1994, she directed staff to schedule 15 meetings throughout the State to describe HB 250, explain the 2% provider tax, and inform members that \$52 million annually had been cut from Medicaid and used for other purposes. Someone asked what was Dr Hoven's purpose for holding the "Summer Seminars" across Kentucky? One staff member replied—"to make members mad as Hell—or at least as mad as she is." With guidance and support from Wally Montgomery, Chair of the Legislative Committee, Preston Nunnelley, Chair of the Public Education Committee, and Bill VonderHaar, Chair of KEMPAC, Ardis developed a two-year strategic plan. The plan included challenging the provider tax all the way to the US Supreme Court and filing suit in federal court contesting Medicaid cuts. This public, political, legal, and legislative strategy worked. In 1996, with Governor Patton's

support, the tax was repealed; HB 250 gutted; Medicaid cuts restored; and \$102 million returned to Kentucky physicians for illegal Medicaid cuts.

Following a year as KMA President, she shifted emphasis to the national scene. After completing several difficult assignments for AMA leadership, the AMA House of Delegates elected her to the prestigious Council on Medical Service—she was elected on her first run—a rarity for AMA Councils—especially from a small state.

As you can see, we are extremely proud of Ardis. Her commitment to patients and to this profession is unparalleled. It is my pleasure, on behalf of a grateful Association, to recognize one of KMA's finest leaders. She is an exceptional person, an individual highly deserving of this special honor."

Educational Achievement Award

The recipient of the 1999 KMA Educational Achievement Award was Hiram C. Polk, MD, of

Left, Scott County Delegate Judy Linger, MD, and Jefferson County Delegate Bruce Scott, MD, Louisville, displayed quite different reactions when surprised with the camera flash. Right, Drs Jon Arvin, at the podium, and Michael Hamilton, both of Mt. Vernon, spoke to the House regarding situations they are encountering in their rural practices.

Louisville. President Don Stephens was pleased to present the award to Dr Polk and included the following comments in his presentation:

"The KMA CME Committee received numerous nominations for the award this year, all with outstanding qualifications.

Our recipient has been professor and chair of the Department of Surgery at the University of Louisville for 28 years. We are told he is the longest standing chair in the country. UL medical students have honored him on several occasions with the Golden Apple Award as Outstanding Teacher. It is also a tribute to his success that more than 150 surgeons who have trained at the University of Louisville under his leadership continue to practice in Kentucky.



Left, Hardin County Delegate, David Zoeller, MD, listened closely to the comments of AMA Delegate Robert Goodin, MD.

He has won many other distinguished awards from organizations such as the American Cancer Society, Academy of Surgical Research, and the Southern Medical Association. In addition, he is an Honorary Fellow of the Royal College of Surgeons.

He is a prolific and outstanding writer, having published hundreds of articles, monographs, and books. He is the current editor of the *American Journal of Surgery*, a position he has held since 1986. He also serves on the editorial boards of numerous surgical journals.

His professional involvement includes past presidencies of the KY Division, American Cancer Society; Association for Academic Surgery; Kentucky Surgical Society; Society of Surgical Oncology; Society of University Surgeons; Southern Surgical

Association; and the Southeastern Surgical Congress. He also is a past chair of the American College of Surgeons.

He has been an active and involved member of the Jefferson County Medical Society, Kentucky Medical Association, and American Medical Association, serving on a wide range of committees over the years.

His community involvement is also exemplary, having served on the Boards of several hospitals, Trover Clinic, Goodwill Industries, The Partnership for Organ Donation, Foundation for Biomedical Research and the Kentucky Medical Insurance Company.

This year's honoree received more support letters from colleagues around the state than any other candidate in memory. Many were former residents under his tutelage who spoke of

his influence in their personal and professional lives. Many referred to his ability to inspire enthusiasm about patient care and his excitement for determining the best course of patient management. All noted his commitment to teaching and his tireless efforts to preserve quality in medical education.

He was referred to as 'an inspiration for generations of surgeons now practicing, teaching, and serving as leaders themselves across the nation.' Over and over again, we saw the words—respected physician, teacher, mentor, and role model."

Alliance AMA-ERF

During the first meeting of the House of Delegates, Jan Crase, KMAA Past President, presented AMA Foundation checks to the two medical schools on behalf of the Alliance. Since 1950, the AMA Foundation (formerly AMA-ERF) has continually been supportive of quality medical education, with contributions now exceeding \$2 million annually. The extraordinary fund raising efforts of the AMA Alliance and the generosity of contributing medical families and private enterprise continue to secure the AMA Foundation as a viable support for medical education.

In Kentucky, AMA Foundation funds are given proportionally to the two medical schools as designated by the donors. Laura Schweitzer, PhD, Associate Dean of Faculty Affairs and Student Affairs at the University of Louisville School of Medicine, accepted a check from

Mrs Crase for \$17,949.50, and Emery A. Wilson, MD, Dean of the University of Kentucky College of Medicine, accepted a check for \$20,180.59.

Fifty-Year Members

Those KMA member physicians who have been practicing medicine for 50 years or more were recognized during the President's Luncheon. Achieving that status this year are: Drs Richard A. Allnutt MD, Dayton William H. Anderson MD, Louisville S. Pearson Auerbach MD, Louisville Hulburt W. Bardenwerper MD, Louisville Clem F. Burnett Jr MD, Mayfield George P. Carter MD, Louisa

Arch B. Clark MD, Richmond Colby N. Cowherd MD, Lexington Robert D. Cox MD, Louisville Carson E. Crabtree MD, Louisville Bohdan Cymbala MD, Sarasota James W. Davis MD, Louisville Francis J. Dillard MD, Mayfield William C. Ellis MD, Lexington Meredith J. Evans MD, Middlesboro Gilbert H. Friedell MD, Lexington Morris M. Garrett MD, Covington Muharrem Gultekin MD, Louisville Thomas R. Havens MD, Jeffersonville Walter I. Hume Jr MD, Louisville Douglas H. Jenkins MD, Richmond

William M. Moses MD, Louisville Sara J. Parks MD, Owensboro James T. Ramsey MD, Frankfort Anne C. Dunbar Richman MD, Louisville Paul Schneck MD, Seymour Forest F. Shely MD, Campbellsville John M. Smith MD, Beattyville Chester B. Theiss Jr MD, Borden Faull S. Trover Sr MD, Madisonville Frank L. Yarbrough MD, Owensboro

In Memoriam

During the first House of Delegates meeting, Secretary-Treasurer William P. VonderHaar, MD, requested that the audience stand for a moment of silence in memory of those physician



Northern Kentucky Delegate Nancy Swikert, MD, engaged in resolution discussion before the House.



Left, Jefferson County Delegate Samuel Eubanks, MD, studied the resolutions. Right, Past President Ken Peters, MD, and 5th District Trustee Dan Varga, MD, discussed pertinent details of a resolution.

members who had died in the last year. A list of the deceased appears on page 557 of this *Journal*.

KEMPAC

The 37th KEMPAC Seminar Banquet was held during this year's Annual Meeting on Monday, September 27, at the Hyatt Regency Hotel, Lexington. A large audience of physicians, spouses, Kentucky State Representatives, Senators, and their staff heard opening remarks by KMA President Donald R. Stephens, MD. The featured speakers were Senator David L. Williams, Senate Republican Leader, and Representative Jody Richards, Speaker of the House. KEMPAC Chair, Robert D. Woods, MD, Lexington, presided at the meeting.

House Action Summary

The Association's policymaking body, the House of Delegates,

met on September 27 and again on September 29 and considered more than 40 reports, more than 30 Resolutions, and several organizational and special reports. Highlights of House actions are listed below. Please refer to the House of Delegates section in this *Journal* for a complete text of the Committee Reports and Resolutions.

- Called for a study of administrative and paperwork burdens imposed upon physicians and patients by managed care.
- Supported regulations or legislation exempting drugs administered and dispensed by physicians from sales tax.
- Encouraged adequate funding for the U of L off campus teaching center at Madisonville.
- Opposed mandatory Hospitalist programs.
- Recommended that all payers of medical services include cervical and colorectal screening as covered services.

- Recognized the necessity for and expansion of cancer screening and the development of a screening registry.
- Commended the development of the Kentucky Breast Cancer Task Force.
- Recommended the repeal of Federal "Stark Laws."
- Supported legislation requiring that only physicians determine "medical necessity."
- Recommended that physicians be permitted to charge a reasonable fee for copies of medical records to patients.
- Supported efforts to obtain antitrust relief for physicians to permit collective negotiation with insurance companies.
- Directed KMA support legislation to prohibit "All or Nothing" or so called "All Products" clauses in provider agreements.
- Recommended that managed care compliance should include
 - Establishing criteria for approval of testing

- Payment for administrative cost of obtaining approvals
- Published 3 day appeal procedure so that patients are not delayed and the medical office is not placed at jeopardy for mismanagement of the patients care.
- Encouraged public awareness of the necessity of immunizations for the elderly.
- Established prompt payment mechanisms, including the definition of clean claims, and opposed arbitrary "down coding" of claims by insurers.
- Recommended physicians be reimbursed by insurers while going through the accreditation process.
- Recommended that Phase I Tobacco Settlement funds be allocated as follows
 - 50% to expand Medicaid
 - 15% to transition Kentucky agriculture from a tobacco-based economy to alternative crops and services
 - 15% to early childhood development and children's health and prevention services
 - 5% to provide research grants to Kentucky's medical schools for tobacco-related illnesses
 - 15% to reduce teen smoking, fund smoking cessation and education programs.
- Encouraged the State Board of Education to increase KERA test score weights for health education so that local school authorities will increase health education in school curricula.
- Declared that medical review by a physician constitutes the practice of medicine and should fall under the jurisdiction of the Kentucky Board of Medical Licensure.
- Recommended legislation to require all physicians complete the same residency-training requirement for medical licensure.
- Continued support and encouragement for KMA's Kentucky Physician Care (KPC) program, which has treated over 300,000 patients free of charge since 1985. Recognized the 2000 practicing Kentucky physicians for participating in the KPC.
- Recommended that a plenary session, devoted to issues related to cervical cancer, be held at the 2000 KMA Annual Meeting.
- Adopted an updated policy/guidelines on health system reform.
- Stressed the importance of perinatal smoking cessation, folic acid intake by women of childbearing age, and the importance of newborn screening for congenital adrenal hyperplasia. Also recommended and acknowledged the importance of partnerships in the private and public sector to accomplish these objectives.

Attendance

This year's KMA meeting attracted a crowd of 1,505. Physicians numbered 721 and medical students 92, resulting in a very successful 149th KMA Annual Meeting at the Hyatt Regency Hotel/Lexington Center in Lexington. The 2000 Annual Meeting will be held in Louisville. The Board of Trustees has again selected the very accommodating



Jane Bramham, MD, Delegate from Warren County, voiced a strong interest in a resolution before the House.

and spacious Hyatt Regency Hotel/Commonwealth Convention Center to house the meeting. Over 22 specialty groups and an estimated 2200 registrants are expected to attend.

Please mark your calendars to attend the 2000 KMA Annual Meeting to be held September 17-21.



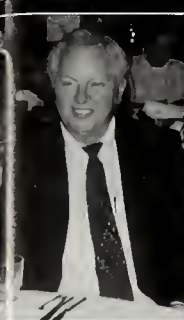
Senator Brett Guthrie; Mrs Stephen Nunn; Representative Stephen Nunn.



Representative Jody Richards, Speaker of the House.



Senator Marshall Long; KEMPAC Board Chair Robert D. Woods, II, MD.



KEMPAC Board Chair Robert D. Woods, II, MD.



Senator David Williams, Senate Majority Leader.



KEMPAC Chair Woods; Representative Ruth Ann Palumbo; Senator Tim Shahlmussy.



Senator Katie Stine; Representative Jon Drand.



William P. Vonderhaar, MD; Representative Harry Moberly.



Mr Stein; Representative Kathy Stein; Mr Westrom; Representative Susan Westrom.



Mrs Preston Nunneley; Mrs R.J. Palmer; Representative R.J. Palmer.

A distinguished group of state leaders, KEMPAC members, and their spouses attended the KEMPAC Seminar Banquet held during the Annual Meeting. KEMPAC Chair Robert D. Woods, MD, presided at the meeting. Several in attendance are pictured in this four-page feature.



Representative Jodie Haydon; Representative Jeffrey Hoover; Richard Miles, MD.



J. Gregory Cooper, MD; Representative Tom McKee; Mrs Don Stephens.



KMA Executive Vice President William T. Applegate; KMA State Legislative Chair Wally O. Montgomery, MD.



Outgoing KMA President Don Stephens, MD; Speaker of the House, Representative Jody Richards.



Senator Dan Kelly; KMA National Legislative Chair Donald C. Barton, MD; Senator David Williams; Representative Danny Ford.



Past KEMPAC Chair William B. Monnig, MD; James P. Farrell, MD; Senator Jack Westwood.



Carol Kirkwood; Mike Kirkwood, MD.



*Left column, from top: Mrs. Andrew Pulito;
Andrew Pulito, MD; Mrs David Stephens;
David Stephens, MD.*

*J. Michael Moore, MD; Representative Jesse
Crenshaw; Senator Ernesto Scorsone.*

*Representative Pete Worthington; Senator Dick
Roeding; Mrs Dick Roeding; Senator Ernie
Harris.*



*Representative Charles Walton; Representative
Joe Fisher; Allen E. Hallquist, MD.*



Below: Representatives Paul Marcotte and Jim Callahan



Mrs Robert Damron; Representative Robert Damron; Charles Garrett, MD.



Representative Carolyn Belcher; Preston P. Nunnolley, MD; Marilyn Clark, Chief Administrative Assistant to the Speaker of the House.



Representative Royce Adams.



Senator Vernie McGaha; Don Brown, MD; Danny Clark, MD.



Representative Jim Gooch; Martin Tori, Senator Elizabeth Tori.



Representative Tim Feeley; Michael Dee, MD; Senator Dan Seum; Representative Gary Tapp



KMA/AMA 2000: A MEDICAL ODYSSEY

MEMBER-GET-A-MEMBER CAMPAIGN

Everyone knows that the personal approach is the most effective method of recruiting members. The impact is even greater when you make the call! The KMA/AMA Member-Get-A-Member Campaign is designed to assist you in locating and contacting non-members in your area. You may choose to recruit any physician in your area who has completed medical training and is in active practice, eg, hospital staff colleagues, alumni from your medical school, physicians in your specialty, or nonmembers in a particular target group. You will receive a Recruitment Kit containing support materials when you sign up.

ENJOY THE REWARDS!

KMA awards for new active KMA members recruited:

1-3 members	Waterman Pen
4-6 members	Franklin Digital PDR
7-9 members	Digital Camera
10+ members	Laptop Computer or \$1500 Computer Accessory Pkg.

AMA awards for new active AMA members recruited:

1-3 members	Quartz Desk Clock/ Business Card Holder
4-6 members	Galaxy Radio Alarm Clock
7-9 members	Computer Organizer Bag
10+ members	Palm Pilot

Complete this form and return to Kentucky Medical Association Membership Department to get started today.

☐ Please send AMA materials.

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Please provide me with a list of potential members based on the following categories:

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ROLL CALL

1999 House of Delegates

1st Meeting September 27, 1999

2nd Meeting September 29, 1999

OFFICERS

		First Meeting	Second Meeting
Speaker	John W. McClellan, Jr, MD	Present	Present
Vice-Speaker	Thomas K. Slabaugh, MD	Present	Present
President	Donald R. Stephens, MD	Present	Present
President-Elect	Harry W. Carloss, MD	Present	Present
Vice-President	Donald R. Neel, MD	Present	Present
Secretary-Treasurer	William P. VonderHaar, MD	Present	Present
AMA Delegate	Donald C. Barton, MD	Present	Present
AMA Delegate	Wally O. Montgomery, MD	Present	Present
AMA Delegate	Robert R. Goodin, MD	Present	Present
AMA Delegate	Ardis D. Hoven, MD	Present	Present
AMA Delegate	Donald J. Swikert, MD	Present	Present
AMA Alternate Delegate	Bob M. DeWeese, MD	Present	Present
AMA Alternate Delegate	J. Gregory Cooper, MD	Present	Present
AMA Alternate Delegate	Preston P. Nunnelley, MD	Present	Present
AMA Alternate Delegate	William B. Monnig, MD	Present	Present
AMA Alternate Delegate	Baretta R. Casey, MD	Present	Present

TRUSTEES

District			
First District	Robert C. Hughes, MD	Present	Present
Second District	David A. Watkins, MD	Present	Present
Third District	Uday V. Dave, MD	Present	Present
Fourth District	Eugene H. Shively, MD	Present	Present
Fifth District	Daniel W. Varga, MD	Present	Present
Sixth District	John T. Burch, II, MD	Present	Present
Seventh District	John M. Patterson, MD	Present	Present
Eighth District	Thomas E. Bunnell, MD	Present	Present
Ninth District	J. Gregory Cooper, MD	Present	Present
Tenth District	Andrew R. Pulito, MD	Present	Present
Eleventh District	Richard A. Stone, MD	Present	Present
Twelfth District	Donald E. Brown, MD	Present	Present
Thirteenth District	Kenneth R. Hauswald, MD	Present	Present
Fourteenth District	Baretta R. Casey, MD	Present	Present
Fifteenth District	Meredith J. Evans, MD	Present	Present

ALTERNATE TRUSTEES

District			
First District	Carolyn S. Watson, MD	Present	Present
Second District			
Third District	C. R. Dodds, MD	Present	Present
Fourth District	Brian F. Wells, MD	Present	Present
Fifth District	Susan M. Berberich, MD	Present	Present
Sixth District	J. Michael Pulliam, MD	Present	Present
Seventh District	Kenneth L. Oder, MD	Present	Present
Eighth District	James P. Farrell, MD	Present	Present
Ninth District	Judy M. Linger, MD	Present	Present
Tenth District	John R. White, MD	Present	Present
Eleventh District	Suvas G. Desai, MD	Present	Present
Twelfth District	David C. Liebschutz, MD	Present	Present
Thirteenth District	Maurice J. Oakley, MD	Present	Present
Fourteenth District	Charles G. Nichols, MD	Present	Present
Fifteenth District			

PAST PRESIDENTS

Past President	C. Kenneth Peters, MD	Present	Present
Past President	William H. Mitchell, MD	Present	Present
Past President	Danny M. Clark, MD	Present	Present
Past President	Robert R. Goodin, MD	Present	Present
Past President	Ardis D. Hoven, MD	Present	Present

DELEGATES FIRST DISTRICT

		First Meeting	Second Meeting
BALLARD	Martha C. Robinson, MD	Present	Present
CALLOWAY	Robert C. Hughes, MD	Present	Present
	Robert T. Williams, MD	Present	Present
CARLISLE			
FULTON	Louis L. Seng, MD	Present	Present
GRAVES	Charles E. Bea, MD	Present	Present
	Thomas G. Russell, Jr, MD	Present	Present
HICKMAN	Bruce C. Smith, MD	Present	Present
LIVINGSTON			
MARSHALL			
MCCRACKEN	Francis J. Block, III, MD	Present	Present

SECOND DISTRICT

DAVIESS	Richard L. Gruenewald, MD	Present	Present
	William C. Harrison, MD	Present	Present
	David E. Jones, MD	Present	Present
	Robert M Kirk, MD	Present	Present
	C. Mark Millsap, MD	Present	Present
	Anwarul Quader, MD	Present	Present
	Terry Tyler, MD	Present	Present
	William L. Tyler, III, MD	Present	Present
HANCOCK			
HENDERSON	John S. Cave, MD	Present	Present
	Marshall G. Howell, III, MD	Present	Present
	Scott A. Watkins, MD	Present	Present

McLEAN
OHIO
UNION
WEBSTER

THIRD DISTRICT

CRITTENDEN	Gary V. James, MD	Present	Present
HOPKINS	Wallace R. Alexander, MD	Present	Present
	James M. Bowles, MD	Present	Present
	Uday V. Dave, MD	Present	Present
	Mohan K. Rao, MD	Present	Present
MUHLENBERG	James S. Brashear, MD	Present	Present
PENNYRILE (Caldwell, Christian, Lyon, Todd, Trigg counties)			
	Robert B. Bressler, MD	Present	Present
	Guinn S. Cost, MD	Present	Present
	John E. Cotthoff, MD	Present	Present
	Peter R. Isele, MD	Present	Present
	Daniel A. Lopez, MD	Present	Present
	J. Nicholas Terhune, MD	Present	Present

FOURTH DISTRICT

BRECKINRIDGE			
BULLITT	Dan Arnold, MD	Present	Present
GRAYSON	Gay Fulkerson, MD	Present	Present
GREEN	William L. Shuffett, MD	Present	Present
HARDIN-LARUE	Chris J. Godfrey, MD	Present	Present
	Lucian Yann Moreman, II, MD	Present	Present
	Jeffrey B. Richardson, MD	Present	Present
	David Zoeller, MD	Present	Present
HART			
MEADE			
MARION	Daniel V. Hunt, MD	Present	Present
NELSON			
TAYLOR	David A. Montgomery, MD	Present	Present
WASHINGTON	Brian Wells, MD	Present	Present

FIFTH DISTRICT

JEFFERSON	Janice Aaron, MD	Present	
	Joe F. Arterberry, MD		
	Susan M. Berberich, MD	Present	
	David Bizot, MD	Present	
	Susan Bornstein, MD	Present	
	David Bybee, MD	Present	Present
	Warren M. Cox, IV, MD	Present	
	David Cundiff, MD	Present	
	Mary H. Davis, MD	Present	
	Leah J. Dickstein, MD		
	David L. Doering, MD		
	John H. Doyle, MD		
	Elmer E. Dunbar, MD	Present	
	Samuel G. Eubanks, Jr, MD	Present	
	Beverly M. Gaines, MD		
	Hoyt Gardner, MD	Present	
	Julius T. Gavin, Jr, MD	Present	
	Carolyn B. Gleason, MD		
	Robert Allan Goodin, MD	Present	
	Manuel Grimaldi, MD		
	James B. Haile, MD		
	Harold Haller, MD	Present	
	Terry Henkel, MD	Present	Present
	J. William Holmes, MD	Present	
	Walter I. Hume, Jr, MD	Present	
	Barbara Sue Isaacs, MD	Present	
	Margie Rae Joyce, MD		
	Virginia T. Keeney, MD	Present	
	Glenn E. Lambert, Jr, MD		
	Michael T. Macfarlane, MD	Present	Present
	Charles F. Mahl, MD		
	Thomas L. Matthew, MD		
	James G. O'Brien, MD	Present	
	James E. Redmon, MD	Present	Present
	K. Thomas Reichard, MD	Present	
	Barton Reutlinger, MD	Present	Present
	Melinda G. Rowe, MD	Present	
	Samuel R. Scheen, III, MD	Present	
	George R. Schrod, Jr, MD	Present	
	George Randolph Schrod, MD	Present	
	Edward L. Scofield, MD	Present	
	Bruce A. Scott, MD	Present	
	Monica Ann Shaw, MD	Present	
	Rajesh K. Sheth, MD	Present	
	Victor James Shpilberg, MD		
	Alfred L. Thompson, MD		
	Robert S. Tillett, Jr, MD		
	Regulo J. Tobias, MD		
	Molloy G. Veal, III, MD	Present	
	Kathy M. Vincent, MD		
	Henry J. Walter, MD		
	Sam Weakley, MD	Present	
	Fred A. Williams, Jr, MD	Present	
	James Anthony Wright, MD		
	C. Milton Young, III, MD	Present	Present
	George H. Zenger, MD	Present	
	Cynthia M. Zinner, MD	Present	Present

SIXTH DISTRICT

ADAIR			
ALLEN			
BARREN	Warren J. Eisenstein, MD		
	John M. Smith, MD		
BUTLER.....	Richard T. Wan, MD		
CUMBERLAND	Joseph D. Skipworth, MD		

EDMONSON	Omkar N. Bhatt, MD		
LOGAN			
METCALFE	Lawrence P. Emberton, MD		
MONROE	James E. Carter, MD		
SIMPSON.....	J. Michael Pulliam, MD	Present	Present
WARREN.....	James F. Beattie, Jr, MD	Present	Present
	Jane R. Bramham, MD	Present	Present
	Janice L. Bunch, MD		Present
	Robert J. Emslie, MD	Present	Present

SEVENTH DISTRICT

ANDERSON			
CARROLL.....	Samer H. Hussein, MD		
FRANKLIN	Joseph J. Dobner, MD		
	Arba L. Kenner, MD		
	John M. Patterson, MD		
GALLATIN	Benjamin Kutnicki, MD	Present	Present
GRANT			
HOSS (Henry, Oldham, Shelby, Spencer counties)			
	M. Brooks Jackson, II, MD		
	David A. Jones, MD		
	Kenneth L. Oder, MD		
	Ronald E. Waldrige, MD	Present	Present
	Ronald E. Waldrige, II, MD		Present
OWEN			
TRIMBLE	Winston Y. Yap, MD		

EIGHTH DISTRICT

NORTHERN KENTUCKY (Boone, Campbell, Kenton counties)			
	Gordon W. Air, MD		
	Christopher F. Bolling, MD		
	Michael K. Davenport, MD		Present
	Daniel G. Fagel, MD	Present	
	James P. Farrell, MD		Present
	Allan E. Hallquist, MD	Present	Present
	Christopher A. Heeb, MD		Present
	Michael R. Kirkwood, MD		
	Joseph C. Martin, MD		Present
	Kevin D. Martin, MD		Present
	Ross McHenry, MD		Present
	Theodore H. Miller, MD	Present	Present
	Neal J. Moser, MD		Present
	Richard E. Park, MD		Present
	Michael L. Robinson, MD		
	B. Robert Schwartz, MD		
	Steven L. Steinkamp, MD		
	Nancy C. Swikert, MD	Present	Present

NINTH DISTRICT

BATH			
BOURBON	Emmett Lee Tate, MD	Present	
BRACKEN			
FLEMING			
HARRISON	Douglas C. Crutcher, MD		
MASON	Alfred M. Sessler, DO		Present
NICHOLAS	Ana Rinaldini, MD		
PENDLETON			
ROBERTSON			
SCOTT	Judy M. Linger, MD	Present	Present

TENTH DISTRICT

FAYETTE.....	James W. Baker, MD	Present	Present
	James R. Bean, MD		Present

David J. Bensema, MD	Present	
Paul V. Brooks, MD		
Frank A. Burke, MD	Present	
Terry David Clark, MD		Present
John W. Collins, MD	Present	Present
Waller Lisle Dalton, MD	Present	Present
James E. Dunnington, Jr, MD	Present	Present
Ernest L. Fletcher, MD		
Richard D. Floyd, IV, MD		
John M. Fox, MD		Present
Terrence R. Grimm, MD		Present
Michael D. Hagen, MD	Present	
Tamara James, MD		
Magdalene B. Karon, MD	Present	Present
Dennis B. Kelly, MD	Present	Present
Daniel E. Kenady, Sr, MD	Present	Present
Gerald V. Klim, DO		Present
Arthur Lieber, MD	Present	Present
James W. Matthews, MD	Present	Present
W. Porter Mayo, MD		Present
John M. Moore, MD	Present	Present
William D. Newton, MD		
William N. O'Connor, MD		
Charles L. Papp, MD		Present
Barbara A. Phillips, MD	Present	Present
John W. Poundstone, MD	Present	Present
Mark W. Rukavina, MD		
Nat H. Sandler, MD	Present	Present
F. Douglas Scutchfield, MD	Present	Present
Susan E. Spires, MD		
David B. Stevens, MD	Present	Present
John D. Stewart, MD	Present	Present
Dale E. Toney, MD	Present	Present
Thomas H. Waid, MD	Present	Present
Henry G. Wells, Jr, MD		
Emery A. Wilson, MD	Present	
William O. Witt, MD	Present	Present
Phyllis J. Corbitt MD		

JESSAMINE
WOODFORD

ELEVENTH DISTRICT

CLARK	Daniel Alan Ewen, MD	Present	
ESTILL	John A. Patterson, MD		
JACKSON			
LEE	James B. Noble, MD		
MADISON	William R. Allen, MD	Present	Present
	Douglas G. Owen, MD	Present	Present
	Richard A. Stone, MD	Present	
MONTGOMERY			
MENIFEE			
OWSLEY			
POWELL			
WOLFE	Paul F. Maddox, MD		

TWELFTH DISTRICT

BOYLE.....	Brian E. Ellis, MD		
	Scott B. Scutchfield, MD	Present	Present
CASEY			
CLINTON.....	Michael Lee Cummings, MD		
GARRARD	H. Mac Vandiviere, MD	Present	Present
LINCOLN			
MCCREARY			
MERCER	George W. Noe, MD		

PULASKI	Donald E. Brown, MD	Present	Present
	Dana L. Gibson, MD		Present
	Mark D. Huffman, MD		Present
	Billy Joe Parson, MD	Present	Present
	James D. Wilson, MD	Present	
ROCKCASTLE.....	Michael D. Hamilton, MD	Present	Present
RUSSELL	H. Michael Oghia, MD		
WAYNE			

THIRTEENTH DISTRICT

BOYD	George K. Aitken, MD		
	Maurice J. Oakley, MD		Present
	John R. Potter, MD	Present	Present
	Susan Hess Prasher, MD	Present	Present
	Charles T. Watson, MD	Present	Present
CARTER			
ELLIOTT			
GREENUP			
LAWRENCE.....	Mark B. Kingston, MD		
LEWIS			
MORGAN	George R. Bellamy, MD		
ROWAN.....	Jane F. Wiczowski, MD	Present	

FOURTEENTH DISTRICT

BREATHITT			
FLOYD	James A. Campbell, DO		
	Nicholas R. Jurich, MD	Present	
JOHNSON			
KNOTT.....	W. Grady Stumbo, MD		
LETCHER			
MAGOFFIN			
MARTIN			
PERRY	Gil L. Daley, MD	Present	Present
	Mitchell Wicker, Jr, MD		Present
PIKE	Gregory V. Hazelett, DO		
	Lela C. Maynard, MD	Present	Present
	Charles G. Nichols, MD	Present	Present
	James Steven Shockey, MD	Present	Present

FIFTEENTH DISTRICT

BELL.....	Robert Joseph Gorrell, Jr, MD	Present	Present
	Emanuel H. Rader, MD		Present
CLAY	William E. Becknell, Sr, MD	Present	
HARLAN	Sharon M. Colton, MD	Present	Present
	Sandford Weiler, MD	Present	Present
KNOX	Raymond E. Hayden, MD		
LAUREL			
LESLIE			
WHITLEY	P. Bruce Barton, MD	Present	Present
	William T. Daniel, II, MD		
	Truman Perry, MD	Present	Present

KMA Student Section

UL	Beth Carlross		
UK	LaDonya Reed		

KMA Resident Physicians Section

James E. Wheeler, MD	Present	
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KMA Organized Medical Staff Section

John D. O'Brien, MD		
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The information in the roll call was taken from the attendance record cards signed by the delegates prior to the meetings of the House, September 27 and September 29.

I 49th ANNUAL MEETING

**Kentucky
Medical
Association**





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REFERENCE COMMITTEES

Special appreciation to the Chairs and members of the Reference Committees for working so diligently to study committee reports, resolutions, and make recommendations to the full House of Delegates.



(L to R) Reference Committee A: LaDonya Reed, Lexington, Medical Student Section; Terry W. Tyler, MD, Owensboro; Theodore H. Miller, MD, Edgewood, Chair; K. Thomas Reichard, MD, Louisville; Charles G. Nichols, MD, Pikeville; John W. Collins, MD, Lexington.



Reference Committee B: Daniel E. Kenady, Sr, MD, Lexington; James E. Wheeler, II, MD, Madisonville, Resident Physicians Section; James F. Beattie, Jr, MD, Bowling Green; Charles Bea, MD, Mayfield; Molloy G. Veal, MD, Louisville; Ronald E. Walldridge, II, MD, Shelbyville, Chair.



Reference Committee C: Michael T. Macfarlane, MD, Louisville; Gil L. Daley, MD, Hazard; Lela C. Maynard, MD, Pikeville, Chair; Billy Joe Parson, MD, Somerset; Dale E. Toney, MD, Lexington; William L. Tyler, III, MD, Owensboro.



Reference Committee D: Sharon M. Colton, MD, Evarts; N. Roger Jurich, MD, Prestonsburg; Marshall G. Howell, III, MD, Henderson; Susan G. Bornstein, MD, Louisville, Chair; John D. Stewart, II, MD, Lexington; Lucian Y. Moreman, MD, Elizabethtown.



Reference Committee E: James E. Redmon, MD, Louisville; Jane R. Bramham, MD, Bowling Green; Jeffrey B. Richardson, MD, Elizabethtown; Barbara A. Phillips, MD, Lexington, Chair; Scott A. Watkins, MD, Henderson. James S. Shockey, MD, Pikeville, is not pictured.

The Philip H. Stewart, MD Memorial Meeting of the Kentucky Medical Association

**Digest of Proceedings of the Regular Session of the*

House of Delegates

John W. McClellan, MD, Henderson

Speaker of the House

Thomas K. Slabaugh, MD, Lexington

Vice Speaker of the House

Presiding

First Meeting September 27, 1999

John W. McClellan, MD, Speaker of the KMA House of Delegates, called the first meeting of the 149th Session of the House of Delegates to order at 10:00 AM on Monday, September 27, 1999, at the Hyatt Regency Hotel, Lexington, Kentucky. He introduced the Vice Speaker, Thomas K. Slabaugh, MD, and KMA's Legal Counsel, Charles J. Cronan, IV, Louisville.

Dr McClellan announced that at last year's meeting, the House voted to invite a representative of the Kentucky Academy of Physician Assistants to be an official observer at meetings of the House of Delegates. He then introduced Patrick Cafferty of Paducah who had been designated by the Academy to serve in this capacity this year.

Harold L. Bushey, MD, Barbourville, gave the invocation. A motion was made, seconded, and carried to approve the Minutes of the 1998 Session of the House of Delegates as published in the December 1998 *Journal of the Kentucky Medical Association*.

William P. VonderHaar, MD, Louisville, Secretary-Treasurer, announced that the Scientific Session would begin at 8:30 AM on Tuesday, September 28, and the President's Luncheon would be held on Wednesday, September 29, at which time the new President would be installed.

Dr VonderHaar encouraged all delegates to get involved in the 2000 Member-Get-A-Member Campaign and indicated that personalized recruitment kits were available for their use.

Dr VonderHaar announced that the Kentucky Medical Group Management Association would be meeting in conjunction with the KMA meeting, and also noted special meetings being held on "Collective Bargaining for Physicians" and "Y2K—A Non-negotiable Deadline."

Dr VonderHaar encouraged all delegates to visit the KMA Exhibit Hall and the "Health Fair" area of the hall, and to enter the "1999 Great American Giveaway" contest.

Dr VonderHaar reminded the delegates that reference committees would convene at 1:00 PM. He then asked the House members to stand for

a moment of silence in memory of KMA members who had died since the 1998 meeting.

Mrs Jan Crase, Immediate Past President of the KMA Alliance, was asked to present the Alliance AMA Foundation checks to representatives from the University of Louisville School of Medicine and the University of Kentucky College of Medicine.

Emery Wilson, MD, Dean of the College of Medicine, accepted checks in the amount of \$20,180.59 on behalf of the University of Kentucky, and Laura Schweitzer, MD, Associate Dean of Faculty Affairs and Student Affairs, accepted checks in the amount of \$17,940.50 on behalf of the University of Louisville. Both expressed their appreciation for the donations, and noted that the funds would be used to enhance student activities and assist with scholarships and special programs.

Speaker McClellan then called upon Donald R. Stephens, MD, President, to present the Educational Achievement Award to Hiram C. Polk, MD, Louisville. Dr Stephens noted that Dr Polk is Professor and Chairman of the Department of Surgery at the University of Louisville, having served in that capacity for 28 years. U of L medical students have honored him on several occasions with the Golden Apple Award as Outstanding Teacher, and more than 150 surgeons who have trained at the University of Louisville under his leadership continue to practice in Kentucky today.

A prolific writer, Dr Polk has published hundreds of articles, monographs, and books. He is the current editor of the *American Journal of Surgery*, and serves on the editorial boards of numerous surgical journals. Dr Polk has won many distinguished awards from organizations such as the American Cancer Society, Academy of Surgical Research and the Southern Medical Association. He has been active and involved with numerous professional organizations and his community.

It was pointed out that Dr Polk's nomination received more letters of support from colleagues around the state than any other candidate in memory. All noted his commitment to teaching and his tireless efforts to preserve quality in medical education.

Speaker McClellan then announced that each delegate's packet contained a booklet prepared by the Rules Committee outlining the rules the House should follow in its deliberations. He also noted that a list of reference committee members serving during the 1999 Annual Meeting had been distributed.

Dr McClellan called upon Dr Stephens to give the report of the President. Dr Stephens touched on highlights during the past year. He reported that the Provider Tax had been removed as of August, and noted that members

**Editorial Note: A tape recording was made of the two meetings of the House of Delegates, and any member who wishes to examine the transcript of these Proceedings may visit the Headquarters Office and listen to the recordings.*



of HMOs have become so dissatisfied that managed care is now receiving intense scrutiny. He noted that the Strategic Plan adopted last year is still being used as a blueprint for the Association to follow. Dr Stephens offered thanks to the officers, Board of Trustees, Executive Committee, Quick Action Committee, and KMA staff for all their efforts on behalf of the Association during his year as President.

Following Dr Stephen's report, Jan Crase, Immediate Past President of the KMA Alliance, presented highlights from her written report. Mrs Crase reported that the Alliance celebrated 75 years of service. She acknowledged the assistance and support of many people during the year, and drew particular attention to several areas of endeavor.

In the area of public education, there were efforts toward increasing awareness of breast cancer and osteoporosis, and the SAVE (Stop America's Violence Everywhere) and SMART (Students Made Aware Reject Tobacco) programs were continued. She also reported on some of the other successful projects in which the Alliance had participated relating to legislation, membership, and preserving medical heritage. She encouraged delegates to recruit physicians, particularly young physicians, and their families for membership in the KMA and KMA Alliance.

Dr McClellan introduced the other officers to present their reports. The report of the Speakers was not read. Greg Cooper, MD, Chair of the Board of Trustees, made brief remarks, noting that the Board had enjoyed a successful year and thanking Board members for their efforts. Dr VonderHaar, Secretary-Treasurer, asked that delegates take the time to read this report, and noted that this would be his last report as Secretary-Treasurer. He thanked his fellow officers and KMA staff for their assistance during the nine years he served in that office. Each of the officers' reports and all committee reports were assigned to a reference committee as noted:

Report Number	Reference Committee
1 Report of the President	A
2 Report of the President, Alliance	A
3 Report of the President-Elect	A
4 Report of the Speakers, House of Delegates	A
5 Report of the Chair, Board of Trustees	A
6 Report of the Secretary-Treasurer	A
7 Report of the Editor	A
8 Report of the Delegates to AMA	A
9 Report of the Executive Vice President	A
10 Physician Advisory Committee to Health Kentucky	A
11 Scientific Program Committee	B
12 Scientific Exhibits Committee	B
13 Continuing Medical Education Committee	B
14 Council for Continuing Medical Education	B
15 Cancer Committee	B
16 Physician Workforce Committee	B
17 Organized Medical Staff Section	B
18 Rural Kentucky Medical Scholarship Fund	B
19 Maternal Mortality Study Committee	C
20 Committee on National Legislative Activities	C
21 Committee on State Legislative Activities	C
22 Committee on Professional Liability Insurance	C
23 Committee on Care of the Elderly	C
24 Public Education Committee	C
25 Committee on Complementary and Alternative Therapies	C
26 Committee on Medicaid Managed Care	D
27 Committee to Investigate Changing Trends in Medicine	D
28 Young Physicians Steering Committee	D
29 Resident Physicians Section	D
30 Medical Student Section	D
31 Committee on Managed Care	D
32 KMA Membership Task Force	D
Ad Hoc Committee on Cardiovascular Services	D
33 Committee on Maternal and Neonatal Health	E
34 Technical Advisory Committee on Physician Services (Title XIX)	E
35 Committee on Community and Rural Health	E
36 Committee on Physical Education and Medical Aspects of Sports	E
37 Committee on Child and School Health	E
38 Judicial Council	E
Ad Hoc Committee on Tobacco Settlement Funds	E

New Business

New Business of the House was assigned to the reference committee indicated:

Resolution	Submitted by	Subject	Reference Committee
101	Hopkins County Medical Society	UL Off Campus Teaching Center at Trover Foundation	B
102	Board of Trustees	Section Name Change	A
103	Board of Trustees	Repeal of Stark Law	C
104	Board of Trustees	Mandatory Hospitalist Programs	B
105	Board of Trustees	Determination of Medical Necessity	C
106	Board of Trustees	All Products Clauses	D
107	Board of Trustees	Dues Delinquency Date	A
108	Board of Trustees	2000 Member-Get-A-Member Campaign	D
109	Thomas L. Young, MD Pres., Ky Chapter, AAP	Health Education Curricula	E
110	Jefferson County Medical Society	Managed Care Compliance	D
111	Jefferson County Medical Society	Repeal State Mandated Procedural Counseling	E
112	Jefferson County Medical Society	Ban All-Products Clauses in Kentucky	D
113	Jefferson County Medical Society	Repeal Free Medical Record Mandate	C
114	Jefferson County Medical Society	Expand Medical Practice Act to Hold that Medical Review is the Practice of Medicine	E
115	Jefferson County Medical Society	Anti-Trust Relief	C
116	Jefferson County Medical Society	Out-of-Network Benefits	C
117	Jefferson County Medical Society	Relief for Physicians from Administrative Burdens	A
118	Jefferson County Medical Society	Tobacco Settlement Allocation	E
119	Resident Physicians Section	Immunization for Older Americans	D
120	Board of Trustees	Policy Sunset Provision	A
121	McCracken County Medical Society	Physician Prescribed and Administered Drugs	A
122	Jefferson County Medical Society	Infection Control in the Cosmetic Industry	E
123	Rajesh K. Sheth, MD KY IN Assn of Physicians from India & Amer Coll Of Inter. Med. Graduates	Kentucky State Licensure Requirement for International Medical Graduates	E
124	Fayette County Medical Society	Claims Review Programs and Unilateral Offsets	D
125	Fayette County Medical Society	Service Reimbursement During Credentialing	D
126	Fayette County Medical Society	Pap Smears	B
127	Fayette County Medical Society	Colorectal Cancer Screening	B
128	Board of Trustees	State Action Doctrine	C
129	Board of Trustees	Cancer Screening	B
130	Board of Trustees	Kentucky Breast Cancer Task Force	B
131	Board of Trustees	National Patient Protection Legislation	C
132	Board of Trustees	Out-of-Network Benefits	C
133	Board of Trustees	Claims Review Programs and Unilateral Offsets	D
134	Board of Trustees	Cervical and Colorectal Cancer Screening	B

Dr McClellan then turned the meeting over to Vice Speaker Slabaugh, who indicated that the House had received some late resolutions, the last of which was numbered 99-134. He also reminded the House that an amendment to the Constitution and Bylaws had been proposed and would be presented for a vote at the second meeting of the House on Wednesday night.

Dr Slabaugh reported that two new "tribute" resolutions had been introduced by the Board of Trustees. The first was entitled "Tribute to Richard A. Kielar, MD" and the second, "Tribute to Richard F. Hench, MD."

As each resolution was read, a motion was made, seconded, and carried to adopt each as written. It was also announced that on Sunday evening Dr Hench had been presented with a framed portrait that will hang in the KMA Headquarters.

Tribute to Richard A. Kielar, MD

Board of Trustees

WHEREAS, Richard A. Kielar, MD, outstanding eye physician and surgeon, has served his profession and patients with great dignity; and

WHEREAS, Richard A. Kielar, MD, served as Chair of the KMA Scientific Exhibits Committee from 1976-1999 and has freely given of his time and scientific expertise to this Association for 24 years; and

WHEREAS, the efforts of Richard A. Kielar, MD, immeasurably assisted the Kentucky Medical Association's reputation for presenting one of America's finest scientific medical meetings; and

WHEREAS, Richard A. Kielar, MD, retired as Chair of the Scientific Exhibits Committee upon his retirement from practice in 1999; now therefore, be it

RESOLVED, that the 1999 KMA House of Delegates pays special tribute and respect to Richard A. Kielar, MD, for his devotion to his patients and his profession; and be it further

RESOLVED, that this House of Delegates expresses its sincere thanks and appreciation for his work as Chair of the KMA Scientific Exhibits Committee; and be it further

RESOLVED, that a framed copy of this Resolution is presented to Doctor Kielar with this Association's highest regard and its wishes for a happy and well-deserved retirement.

Tribute to Richard F. Hench, MD

Board of Trustees

WHEREAS, Richard F. Hench, MD, has served this Association as Trustee, Chair of the Board for two terms, Vice Chair, Vice President, President-Elect and President; and

WHEREAS, Richard F. Hench, MD, received the Kentucky Medical Association's Distinguished Service Award in 1988; and

WHEREAS, Richard F. Hench, MD, served in 1986 on behalf of KMA on the Kentucky General Assembly Task Force to Examine Liability Insurance; and

WHEREAS, Richard F. Hench, MD, was a member of the Ad Hoc Committee on Professional Liability Insurance; and

WHEREAS, Richard F. Hench, MD, has served on the Board of Kentucky Medical Insurance Company (KMIC) since 1988 and as its Chair since 1991; and

WHEREAS, his exemplary leadership as Chair of the Board led KMIC to provide a majority of Kentucky physicians with their professional liability insurance; now, therefore, be it

RESOLVED, that the 1999 Kentucky Medical Association House of Delegates recognize and honor Doctor Hench for his devotion and service to his profession, this Association, and the Kentucky Medical Insurance Company; and be it further

RESOLVED, that Richard F. Hench, MD, be presented with a copy of this resolution, and it be a permanent part of the 1999 House of Delegates proceedings.

Vice Speaker Slabaugh announced the meeting locations for the Nominating Committee and for Trustee Districts electing Trustees and Alternate Trustees. These meetings will take place at the close of the House meeting. He indicated which districts would be meeting and read the list of counties falling within those districts. Dr Slabaugh then reminded the delegates that the Nominating Committee would report at the close of the first Scientific Session on Tuesday morning, and noted that the nominations would be read Wednesday night and additional nominations could be made from the floor at that time.

The names of the Nominating Committee members were announced: Barbara Phillips, MD, Lexington, Chair; David E. Bybee, MD, Louisville; J. Roger Potter, MD, Ashland; and Scott A. Watkins, MD, Henderson.

President Stephens then introduced AMA President-Elect Randolph D. Smoak, Jr, MD, who addressed the House of Delegates.

Dr Smoak discussed "the rise and fall of medical care in this nation," drawing parallels with changes in the Bluegrass area of Kentucky. With development taking over the horse country around Lexington, he felt it was becoming increasingly important for all parties to find ways to work together.

Dr Smoak indicated that medicine is facing many challenges now, but has come a long way in many areas such as diagnostic technology, antibiotics, and mass immunizations. He stated that the decline in America has been prompted by the marketplace, which is dominated by cost containment and managed care. Dollars, and not doctors, drive the medical arena today.

Dr Smoak discussed what the AMA is doing to combat this trend. He cited the patient bill of rights, and noted that the AMA supports the Norwood-Dingell Bill, which contains at least four of the major priorities identified in the bill of rights. He stated that the insurance lobby is working hard to defeat this measure. Dr Smoak reported that the AMA is also seeking anti-trust relief for physicians through HR 1304, the Campbell Bill. This legislation would offer some physician protection, and he asked delegates to urge Kentucky's congressman to pass it.

Dr Smoak reported that the AMA has a department dealing with private sector advocacy, a group of about 12 people, which includes lawyers, public relations experts, and others. They challenged the Aetna/Prudential merger, and while they were unable to stop it, did make a strong statement. AMA also supported the Texas State Action Doctrine. Dr Smoak commended the physicians of Louisville who stood up to Aetna to fight the "all products" clause.

Dr Smoak stated that the AMA is working to help physicians regain some influence in their own future. He pointed out that this concept is not a traditional labor union, and physicians will not strike. However, they are committed to good patient care. He noted that each person can make a difference, but the real impact is felt when all physicians work together.

Dr Smoak concluded by expressing congratulations to the Fayette County Medical Society on the celebration of its 200th anniversary.

Vice Speaker Slabaugh thanked Dr Smoak for addressing the House of Delegates and presented him with a copy of *Medicine in the Athens of the West 1799-1950: The History and Influence of the Lexington-Fayette County Medical Society*, authored by W. Porter Mayo, MD, PhD.

The Speaker adjourned the First Meeting at 11:35 AM.

Second Meeting September 29, 1999

John W. McClellan, MD, Speaker, House of Delegates, called the Second Meeting of the 1999 Session of the KMA House of Delegates to order at 7:10 PM on Wednesday, September 29, 1999.

Ken Peters, MD, Jeffersonton, gave the invocation, and Mitchell Wicker, MD, Hazard, Chair of the Credentials Committee, reported that a quorum was present.

Dr McClellan explained the composition of the House of Delegates and indicated those who had voting privileges, including those who were added last year by constitutional amendment—the Deans of the University of Kentucky College of Medicine and University of Louisville School of Medicine; a representative from the Resident Physician Section and the Organized Medical Staff Section; and a student representative from each medical school of Kentucky.

Members of the House were reminded that a new proposed amendment to the Constitution and Bylaws had been presented to the House of Delegates last year and mailed to all delegates for a vote this year. The amendment would give a vote to the Dean of the Pikeville College School of Osteopathic Medicine. The amendment must be approved by a two-thirds vote.

A motion, was made, seconded, and carried to adopt the constitutional amendment.

PROPOSED CONSTITUTIONAL AMENDMENT

Article VI, Section 2:

Delegates shall be members of and elected by component county societies in such a manner as may be provided in the Bylaws. The following members shall be designated as ex-officio members of the House of Delegates of the Kentucky Medical Association and entitled to vote: Officers of the Association, Delegates and Alternate Delegates of the American Medical Association, and five immediate Past Presidents; the Dean of the University of Kentucky College of Medicine; the Dean of the University of Louisville School of Medicine; the Dean of the Pikeville College School of Osteopathic Medicine; a representative of the Resident Physician's Section of the Kentucky Medical Association; a student representative of each medical school of Kentucky; and a representative of the Organized Medical Staff Section of the Kentucky



Medical Association. All other Past Presidents and Vice Presidents and Past Chairmen of the Board of Trustees shall be ex-officio members of the House. They shall have the right to speak and debate on the floor of the House but shall not have the right to make a motion, introduce business or an amendment, or vote.

The Speaker then called on Dr VonderHaar to make announcements. Secretary-Treasurer VonderHaar recognized guests from neighboring state medical associations who had attended the Annual Meeting. These included Bernard Emkes, MD, President of the Indiana State Medical Association; Lawrence E. Blanchard, III, MD, President of the Medical Society of Virginia; and David J. Utlak, MD, President of the Ohio State Medical Association.

It was announced that two new tribute resolutions were being introduced by the Board of Trustees. The first was entitled "Tribute to Donald C. Barton, MD," honoring him for his service as Trustee, Vice-Chairman and Chairman of the Board; Vice-President; President-Elect and President; and Delegate to the American Medical Association; and his adept stewardship on behalf of the profession within the local, state and national political arenas. The resolution was read, and a motion was made, seconded, and carried to adopt it. A framed copy of the resolution was presented to him, and it was noted that a framed portrait of Dr Barton was presented to him Sunday evening and will hang in the KMA Headquarters.

Tribute to Donald C. Barton, MD Board of Trustees

WHEREAS, Donald C. Barton, MD, became a member of the Board of Trustees in 1978 and has provided his leadership and talents to the Association, and his profession for 21 years; and

WHEREAS, during that period, Doctor Barton was elected and has served as Trustee, Vice-Chairman and Chairman of the Board; Vice-President; President-Elect and President; and Delegate to the American Medical Association; and

WHEREAS, Doctor Barton received the KMA Distinguished Service Award in 1993, the highest honor the Association can confer on a member; and

WHEREAS, Donald C. Barton, MD, has gained the respect and acknowledgement of his peers in Kentucky and nationwide for his championship of the ideals of medicine at the highest levels of American medical policy development within the House of Delegates of the American Medical Association; and

WHEREAS, his adept stewardship on behalf of the profession is further recognized within the local, state and national political arenas; and

WHEREAS, Doctor Barton has announced his retirement as AMA Delegate at the end of this year, which will bring to a close his service as a member of the Board of Trustees; now, therefore, be it

RESOLVED, that this House of Delegates does hereby recognize and honor Donald C. Barton, MD, for his devotion, service and commitment to this Association, the AMA and all physicians; and be it further

RESOLVED, that Doctor Barton be presented a copy of this resolution with the esteem of the Association, and that it be permanently recorded in the proceedings of this House of Delegates.

The second tribute resolution was entitled, "200th Anniversary of the Fayette County Medical Society." The resolution was read, and a motion was made, seconded, and carried to adopt it. A frame copy of the resolution was presented to W. Porter Mayo, MD, author of *Medicine in the Athens of the West 1799-1950: The History and Influence of the Lexington-Fayette County Medical Society*, who made some acceptance remarks. A framed copy was also presented to J. Michael Moore, MD, President of the Fayette County Medical Society.

200th Anniversary of the Fayette County Medical Society Board of Trustees

WHEREAS, in 1999 we observe the 200th Anniversary of the Lexington Medical Society and its successor, the Fayette County Medical Society; and

WHEREAS, its original members and successors have been major contributors to the development, influence, and success of modern medicine; and

WHEREAS, through the founding of county and local medical societies the idea was germinated to establish state, national, and specialty medical societies and associations; and

WHEREAS, *Medicine in the Athens of the West 1799-1950: The History*

and Influence of the Lexington-Fayette County Medical Society, authored by W. Porter Mayo MD, PhD, well documents the history and development of organized medicine in this period; now, therefore, be it

RESOLVED, that the 1999 KMA House of Delegates honors and affirms the establishment of the Fayette County Medical Society and its 200 years of leadership in Kentucky and Western United States medicine; and be it further

RESOLVED, that this 1999 House of Delegates remembers and reveres the distinguished names of Fayette County Medical Society's noble leaders and founders including Samuel Brown, MD; Daniel Drake, MD; and Ephraim McDowell, MD; and be it further

RESOLVED, that this resolution be made a permanent part of the minutes of this House of Delegates; and be it further

RESOLVED, that a framed copy of this resolution be formally presented in the final session of the 1999 House of Delegates to the author of *Medicine in the Athens of the West 1799-1950: The History and Influence of the Lexington-Fayette County Medical Society*, W. Porter Mayo, MD, PhD; and be it further

RESOLVED, that a copy of this resolution be presented to the President of the Fayette County Medical Society and its Delegates during the final session of the 1999 KMA House of Delegates with the esteem and appreciation of the Kentucky Medical Association.

Greg Cooper, MD, Chair of the Board of Trustees, was asked to present the Board's report, and made a few comments, indicating that the Board's position would be stated on individual issues as they arose.

Speaker McClellan called on William Monnig, MD, to present the KEMPAC report.

1999 KEMPAC Report

Tonight I am pleased to report that we have some "good news" and some "bad news." First, let's talk about the "bad news." Kentucky, like most states, has witnessed a rather sharp decline in its political action committee membership. At this point in 1998 we had 993 members. This year we have 800 members, a decline of 193 or approximately 20%. For instance, only about 19% of practicing Kentucky physicians normally join KEMPAC—or in other words, is carrying the political water for the profession. According to the *Courier-Journal*, KEMPAC and Kentucky physicians were the "big contributors" to the political candidates in the 1996 and 1998 political cycle. Based upon physician response to KEMPAC this year, we seem to have become as complacent as we were in the 1993-94 Brereton Jones years.

Joining together, we can pool our political resources to support candidates who share our vision of patient care:

- Candidates who support our position that a major portion of the tobacco settlement money should be returned to the health and medical sector
- Candidates who believe that medical decisions should be made between the patient and the physician
- Candidates who believe that HMOs and managed care should be accountable when their decisions cause the injury or death of a patient
- Candidates who believe that when questions arise as to whether a service should be covered under an insurance policy or whether a service is necessary, an Independent External Review Panel made up of independent physicians should make the final determination
- Candidates who believe in Tort Reform
- Candidates who believe that the "All or Nothing Clause" should be abolished.

The only way we can elect good men and women to public office is to supply them with both the personal and financial support that this profession is capable of. In the 1996 and 98 cycles, KEMPAC contributed 75% of state legislative contributions on behalf of physicians. Historically, individual physicians contribute very very little. The average annual physician contribution is less than \$25 per year. In 74 Kentucky counties, physicians did not contribute to a single candidate over a four-year period. Sadly, the physicians that do contribute to legislators also belong to KEMPAC—so once again a small 18 or 19% are carrying the load.

KEMPAC costs you \$100 per year—\$8 a month—less than \$2 a week. We need you to join this year as this Association attempts to make dramatic inroads into Managed Care. Tonight, most of the Resolutions you will discuss will involve legislative activity. President Carloss and Legislative Chair Wally Montgomery have an unbelievable legislative agenda which you are establishing tonight.

On the national level, AMA is making a valiant effort to adopt decent patient protections for our patients that protect them from the abuse of big insurers and managed care. Doctor Don Barton is working with our congressional delegation on a daily basis, trying to convince them of the need of patient protection—provider fairness legislation. Remember—\$50 of your dues goes to candidates for the US Congress and US Senate—and \$50 goes to elect state representatives and state senators.

On Monday evening over 50 members of the Kentucky General Assembly, 14 spouses, and 7 key legislative staff attended the annual KEMPAC Seminar. We had the largest crowd in the 37-year history of KEMPAC as we began discussing issues of importance to our patients and the profession. Unfortunately, not less than 10 hours later, your KEMPAC Board met to begin evaluating candidates. We recognized immediately that unless physicians respond strongly in the next 6 months we will be severely hampered in our efforts to assist our friends in 2000. The money will simply not be there.

Big insurance companies and HMOs are making enormous contributions to political parties, and their executives are also responding by making huge contributors directly to candidates. While we can't compete dollar for dollar—we do have that direct access to our elected officials and by contributing—we can make our voices heard. You can begin TONIGHT—the KEMPAC booth is just outside the door—and staff and KEMPAC Board members are ready to accept your personal check. This will be the best \$100 you will ever invest in your practice, your profession, and for your community. The future of patient care and our profession is at stake.

William B. Monnig, MD
Immediate Past Chair

Board Chair Greg Cooper was recognized and introduced two young physicians who had spoken during the Rural Caucus meeting. He asked them to repeat some of their remarks for members of the House. Drs Mike Hamilton and Tony Arvin, both practicing in Mt Vernon, Kentucky, discussed the difficulties they have been experiencing with the Region 5 Medicaid Managed Care Partnership. They indicated that this program has not been working. It has created an administrative burden for the physician, and is having a negative impact on patient care, especially in rural Kentucky. Both spoke against statewide expansion of the program.

The Speaker then turned the proceedings over to Vice Speaker Slabaugh. Dr Slabaugh noted that KMA is aware of the problems being encountered by physicians with Medicaid Managed Care Partnerships and had not endorsed the program, but was waiting to see the results in Regions 3 and 5. He then explained the proceedings for considering reference committee reports and called for reference committee chairs to present their reports.

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE A

Theodore H. Miller, MD, Edgewood, Chair

1. Report of the President
 2. Report of the President, Alliance
 3. Report of the President-Elect
 4. Report of the Speakers, House of Delegates
 5. Report of the Chair, Board of Trustees
 6. Report of the Secretary-Treasurer
 7. Report of the Editor
 8. Report of the Delegates to AMA
 9. Report of the Executive Vice President
 10. Report of the Physician Advisory Committee to Health Kentucky
- Resolution 102 — Section Name Change
(Board of Trustees)
- Resolution 107 — Dues Delinquency Date
(Board of Trustees)
- Resolution 117 — Relief for Physicians from Administrative Burdens
(Jefferson County Medical Society)
- Resolution 120 — Policy Sunset Provision

(Board of Trustees)

Resolution 121 — Physician Prescribed and Administered Drugs
(McCracken County Medical Society)

ITEMS FOR CONSENT

Reference Committee A reviewed the following items and recommends they be filed, by consent of the House, without discussion:

1. Report of the President — filed
2. Report of the President, Alliance — filed
3. Report of the President-Elect — filed
4. Report of the Speakers, House of Delegates — filed
5. Report of the Chair, Board of Trustees — filed
6. Report of the Secretary-Treasurer — filed
7. Report of the Editor — filed
8. Report of the Delegates to AMA — filed
9. Report of the Executive Vice President — filed

Reference Committee A would like to express its appreciation to the authors of the reports which have been filed for their time and energy expended in preparing these reports for the House of Delegates. Reference Committee A recommends adoption of the Consent Calendar as a whole.

Report of the President

At the beginning of the Association year, I pointed out that no organization, group, or profession can match Kentucky physicians and their spouses when it comes to caring for the poor; addressing tobacco, drug, and alcohol abuse; and working to prevent and treat domestic violence. You and your spouses have been leaders in promoting educational reform, funding medical education, and urging Kentucky's political leadership to address health and safety proposals, especially those that threaten our young people.

On the local level, you have operated free clinics for the indigent, uninsured, and homeless. It is fairly common for most medical practices to treat 5-10% of their patients who are unable to pay for medical care. Statewide, 2,000 physicians donate their time and office resources by participating in Kentucky Physicians Care. Without fanfare, we simply proceed quietly about our business and treat our patients—all of our patients—regardless of ability to pay.

We are engaged in our communities and in political life. You have participated in thousands of local projects and fundraisers that benefit your communities. We serve on city councils, boards of education, and boards of health. Many of us belong to local civic clubs and are major participants in fundraising exercises benefiting our community, state, and nation. Historically, physicians have been dismissed within political circles as "aloof" and "above politics." That myth has been exposed. According to the *Courier-Journal*, "Physicians have emerged as big players in politics, and make the largest contributions of any occupational group." Most of us are far more involved in the political life than even the politicians are aware.

We began the year criticizing HMOs and managed care, and will end on a similar note. In August, KMA testified before an interim committee of the Kentucky General Assembly. The committee was seeking to determine the cost-drivers of medical care. My remarks were brief and pointed. Physicians are asking the same exact question. Provider fees have been reduced 30-50%, and on a daily and hourly basis, patients are being denied, delayed, or ignored in their efforts to obtain medical care. Despite HMO and managed care press releases, premium increases for groups are routinely jumping 25-35% annually. Physicians and patients are looking for answers. Only Congress and the General Assembly can probe behind the wall of "proprietary privileged information" thrown up by HMOs and managed care to avoid the truth.

Despite the doom and gloom, I am optimistic that we will overcome the hurdles imposed upon us. Patients and physicians have never been more united. Sooner or later this nation will rise up against a system that rakes 20-40% off the top, and in the same breath denies necessary care. These folks tipped their hands at the outset. They attempted to cram "drive-through" mastectomies and deliveries down the public's throat and even denied women and children direct access to pediatricians and OB-GYNs. That effort created a national furor among women, child advocates, and physicians.

If they continue on this path (and they surely will), the public's response to managed care may well be that "old bugaboo," the single payor system.



Many patients and physicians already prefer Medicare and find it far more efficient to work with than most managed care outfits. HMOs and managed care can't have it both ways. The electorate will not tolerate HMOs and managed care canceling or refusing to insure the poor, elderly, and frail, while opposing government programs for the very ones they refuse to insure.

In closing, I want to express my sincere thanks for your support and assistance. Special thanks to the House of Delegates for providing the opportunity to serve as President, and to a Board of Trustees and staff that always rallied to the cause—often at a moment's notice. Special mention should be made of the Kentucky Medical Association Alliance officers and members for their efforts to improve the lives of Kentuckians. Throughout the year, I have consistently supported united action among county, state, national, and specialty groups. Of all these groups, AMA is most imperiled. Further erosion of AMA is not in the best interests of patients and this profession. Without a single national voice, we become easy pickings. Just ask our neighbors to the North.

We are a proud and a noble profession. Physicians will continue, as we always have, to take care of sick patients, despite their ability to pay. Patients are our friends and allies. The special covenant that binds us to each other will eventually serve to prevail against those who abuse the public trust for profits—whoever they are.

Sonya and I have enjoyed the special camaraderie and friendship while serving as your President. We are "not quite" ready for retirement and look forward to serving patients and the profession in other capacities. Thanks, again, for a great year.

Donald R. Stephens, MD
President

Report of the President, Alliance

It was my privilege to have known Alex Haley, when he and my husband served on the Board of Trustees at Berea College, and one of his favorite sayings was, "When you see a turtle on a fence post you know it had some help in getting there." Well, I had a lot of help this year. By forming coalitions, we reached the following:

HEALTH EDUCATION:

- 88,000 teachers and staff with breast cancer awareness information in their last pay check
- All Alliance members with a seed packet saying, "Mammograms can detect breast cancer when it is only the size of a tiny seed" 178,700 children K-3 with SAVE, anti-violence materials ("Hands are not for Hitting" place mats and "I can Choose" activity booklets)
- Numerous groups with the SMART (Students Made Aware Reject Tobacco) Program
- 55,000 teachers plus the mothers of their students were given osteoporosis information on bookmarks
- Governor Patton proclaimed October 14th SAVE day in Kentucky

AMA FOUNDATION:

- \$46,445.50 was raised for the AMA Foundation
- Established endowed scholarships at both the U of L and U of K Medical Schools

LEGISLATION:

- Conducted two legislative workshops.
- Held a Legislative Day at the capitol and "get acquainted visits" with Legislators
- Wrote a letter to each member of the Kentucky General Assembly

LEADERSHIP DEVELOPMENT:

- 13 leaders attended various training sessions at AMAA in Chicago
- Conducted six statewide leadership workshops
- Served on the KMA Strategic Planning Committee
- A PhD in Measurement Statistics helped establish objective means for evaluating our projects. Meaningful statistics give the organization and its work more credibility.

MEDICAL HERITAGE:

- Produced a documentary video about Dr. Louise Hutchins from Berea, and funding is in place for another one about Dr. C. C. Howard of Glasgow

- Increased funds raised for the McDowell House, which is a state medical heritage treasure

DOCTOR'S DAY:

- **Doctor's Day** was celebrated by getting 3000 bookmarks with osteoporosis information to every library in the state
- One county had the author and outstanding speaker, Dr. Wayne Sotile, as guest speaker for their Doctor's Day dinner

MEMBERSHIP:

- Filmed a **Membership** video to be available for viewing in each county this fall
- The U of L Resident Spouse Group was awarded the HAP award (Health Awareness Project) at the AMAA annual meeting in Chicago

COUNTY AND LOCAL ALLIANCES:

In addition to these statewide efforts, *the counties*, where the real work is done, conducted numerous projects. These projects ranged from cholesterol screening, health fairs, working in community food kitchens, and sponsoring local health careers scholarships, to passing out crisis #800 cards to students 7-12. These cards list all pertinent 800 numbers that teens might need in a crisis such as Rape Hotline, Runaway Hotline, Alcohol Abuse, and Eating Disorders Hotline. They also adopted families at Christmas time, and remodeled and refurbished the family visitation room at a County Department for Social Services. The Counties also held toy drives, purchased a Thermal Imaging Camera for a local fire department and sponsored spouse abuse shelters. They made friendship quilts about the proper use of one's hands and they held workshops on conflict resolution in local schools. One Alliance celebrated a "Day of Peace" with a candlelight vigil with nine other organizations participating along with the Mayor. The Ronald McDonald House and Hospitality House were sponsored by various Alliances. Some continued with the "Growing Healthy" health curriculum that has been implemented in the schools and other counties are looking at the possibility of getting the program started in their areas.

In addition to all the community outreach programs, there were also fun activities including dinners, golf outings, a day at the track, visiting historical places and one county had a Southern Living Cooking School. Some also learned about the various cultures represented in the medical community, and all Alliances provided support to medical families by looking at ways to strengthen relationships within our medical families.

It was a pleasure to serve as President of this outstanding organization with such capable, caring and committed members. The membership consists of talented people from all walks of life with training in most all professions and expertise in most all fields. This wealth of information and ability is available to the KMA just for the asking. The Alliance has the potential to be KMA's greatest asset.

Jan Crase
President

Report of the President-Elect

The Bylaws of the Association require the President-Elect to "assist the President." I have tried my humble best to fulfill this directive but have merely been able to follow, for the most part. Don Stephens has served you and the Association well, and it has been my privilege to accompany and observe him this year. This has been a singular experience and I've learned a great deal.

I have experienced a reaffirmation of the dignity and depth of our profession and simultaneously become intimately familiar with the influences that are working to erode our professionalism both within and without. One of the strongest impressions formed has been the even more critical need for deeper participation by all of us in areas that we all too often disregard or avoid as secondary to our practices. We all worked hard and diligently to attain medical degrees and to function in the medical roles we each chose. To this degree, being a physician has become a right that we earned.

The trust we hold with our patients and the public, however, must be constantly nurtured because this is a privilege. The depth of the profession of medicine is best maintained and grown collectively. Our collective

efforts are diminished in direct proportion to our peers who don't participate. This is the internal erosion I've seen and it's disturbing. We're all aware of the external forces we face. Traditionally, medicine has progressed through the sharing of our science with colleagues. Our privileged profession can't progress unless we likewise share our efforts. This is a theme I feel sincerely about and I hope to encourage it in others.

KMA's sole purpose for being is to further medicine. In addition to all the tasks that are regularly undertaken and reported in this book, there are some specific areas I'd like to address this year. The first is membership recruitment and retention. Last year, KMA started its Member-Get-A-Member campaign and all Delegates were asked to take part. This program will continue this year and I urge everyone to recruit at least one member. We'll provide more information on this program to you, as well as other recruitment ideas, and hope you'll help out.

A key to consensus effort is information and communication. In keeping with the KMA Strategic Plan, intense efforts will be made to communicate with you, and I hope you'll return the favor. Some meetings have already been held with representatives of the American Medical Association to explore our ability to improve technological communication with members, students and residents. Electronic information sharing is not the wave of the future but the state of the art. Just ask your children or grandchildren—or young physicians who grew up with computers.

Last year, this House passed Resolution 122, relating to Vaccine for Children. This resolution called for the expansion of subsidized vaccines for all children and supported then current federal legislation. Since then, KMA leaders have held discussions and meetings with state health officials to explore the possibility of universal vaccinations. Typically, one obstacle is adequate public funding, but the Patton administration has reacted supportively. The potential for establishing this program seems strong. Hopefully, we can pursue this to a positive conclusion.

Two other efforts to further medical care that I plan to focus on are addressed in two resolutions you will be asked to consider. They relate to the Kentucky Breast Cancer Task Force and cancer screening. Together with several other physicians in the state, I had the opportunity to work on the Task Force appointed by Governor Patton. The Task Force made a number of recommendations that will require some long-term follow-up, as well as legislative action. A second focus will be on the expansion of cancer screening efforts in the state. Kentucky is fortunate to have two outstanding cancer centers and quite a few very accomplished physicians who specialize in cancer treatment. Our state also has the misfortune of having some of the country's highest rates of mortality for cervical cancer. This is an obvious area of attention.

The General Assembly will convene in January for its biennial session. This arena will demand a preponderance of our strongest resources. The Legislature is a culminating concentration for the ideas I've mentioned. Collective efforts by physicians were never more crucial than in this context. Issues that challenge the professionalism that is our privilege will dominate—patient protection and patient rights under managed care, determination of medical necessity, mandatory hospitalist programs and others. Medicine, and physicians, will succeed only in proportion to our participation. Stay current on issues; keep in contact with your legislator at his/her convenience; call, write and meet with your legislator. Join KEMPAC.

Your officers and Board of Trustees ably serve this Association and I am honored to have served with them this year. These are all strongly committed individuals. With their help and your support, I pledge my best efforts to serve as your President and thank you for this opportunity and honor.

Harry W. Carlross, MD, FACP
President-Elect

Report of the Speakers, House of Delegates

Your Speakers are pleased to welcome you to the 149th Annual Meeting of the Kentucky Medical Association. This year the meeting memorializes Philip H. Stewart, MD (1867-1934). KMA Historian Eugene H. Conner, MD, has chronicled some of the history of Dr Stewart, who assumed the presidency during the time of World War I. Perhaps a parallel can be drawn between the trials and rigors that confronted our nation at that time with the onslaughts being made against the practice of medicine today. Regardless, it will take our collective efforts as a profession to represent

the interests of our patients against those forces negatively influencing medical care delivery.

Last year, the House of Delegates passed Resolution 98-104, which called for a study of the current anti-trust environment as it relates to physicians and medical practice. This resolution directed KMA to support the efforts of the AMA to review this issue and for KMA to present an educational session during this year's meeting. To this end, a program on collective bargaining has been scheduled for Monday, September 27, from 3:00-4:00 PM. At this meeting, KMA Legal Counsel Charles J. Cronan, IV, will give information about the current status of collective bargaining efforts and the alternatives available to physicians.

In this same vein, Delegates this year will be asked to consider issues relating to a definition of the determination of medical necessity, "all products" clauses being imposed by some insurance carriers, repeal of the "Stark" Law, and the "State Action Doctrine" as it may or may not apply to physicians. These resolutions and the educational session on collective bargaining are ongoing efforts by the Board of Trustees to accommodate the directions of the House and to propose future actions to protect the profession.

You will also be asked this year to vote on the creation of a procedure to codify all KMA policy that this House has enacted through the years. This "sunset" provision would establish a procedure whereby all KMA policy would be periodically reviewed for timeliness and relevancy and either retained or deleted. In the fluid managed care context in which medicine finds itself, it is important that your organization have a base of clear-cut principles from which to operate, and that these principles be kept as up-to-date as possible.

During the first meeting of the House of Delegates, we will be pleased to welcome the President-Elect of the American Medical Association, Randolph D. Smoak, Jr, MD. Dr Smoak is a capable spokesman on behalf of organized medicine, particularly at the national level, and he will provide the House with the latest developments on collective bargaining and other seminal issues.

Your Speakers would like to encourage all Delegates to consult with local constituents not only on issues of business but also on elections that will take place at the meeting. Following the first meeting of the House of Delegates, the Nominating Committee will convene to accept nominations for the positions of Trustee for the 5th, 6th, 8th, 11th, and 15th Districts; and Alternate Trustees for the 2nd, 5th, 6th, 8th, 11th, and 15th districts. In addition, nominations will be accepted for the constitutional offices.

In selecting members to serve on reference committees, your Speakers have given special attention to appointing young physicians, women, and under-represented groups. These criteria are used in addition to geography, physician population density, and expressed interest. If any Delegate would like to serve on reference committees in the future, please contact the Speakers or the staff and make your wishes known, and every effort will be made to accommodate willing participants.

KMA's efforts to involve young and soon-to-be physicians continue. The Young Physicians Steering Committee will sponsor a luncheon on Tuesday, September 28, beginning at 12:00 PM, and the Medical Student Section and Resident Physician Section will conduct their annual meetings at 1:00 on that same Tuesday.

We are pleased to welcome the Kentucky Medical Group Management Association, which will be meeting in conjunction with KMA. This association, which consists of representatives of physician practice groups, will be conducting meetings on Monday and Tuesday, September 27 and 28. This group represents a vital adjunct to "medical practice families," and its coterminous meeting is welcomed.

Your Speakers would like to call your attention to a proposed change to the KMA Constitution, which was mailed to all county medical societies approximately 60 days ago. This change was proposed at the 1998 Annual Meeting, and in accordance with our governing documents, is laid over for a vote at the upcoming meeting. The proposed change would make the Dean of the Pikeville College of Osteopathic Medicine a voting member of the KMA House of Delegates. As you may recall, the 1998 House of Delegates adopted an amendment giving a vote to the Deans of the University of Louisville School of Medicine and the University of Kentucky College of Medicine; a representative from the Resident Physician Section and the Organized Medical Staff Section; and a student representative from each medical school of Kentucky.



As always, your Speakers will remain available throughout the meeting to all Delegates and component societies with questions or concerns to be expressed. Your contact and input are welcomed.

Your Speakers continue to appreciate the trust you have placed in them and are committed to every possible effort to make this meeting suit the needs of the House and the Association.

John W. McClellan, MD
Speaker, House of Delegates

Thomas K. Slabaugh, MD
Vice Speaker, House of Delegates

Report of the Chair, Board of Trustees

The responsibility of the Board of Trustees is to oversee the implementation of the actions taken by the House of Delegates and to provide general direction of the Association's affairs during the interim between meetings of the House. Your Board is composed of the Officers of the Association, 15 Trustees nominated by their district and elected by the House, Speaker and Vice Speaker of the House, and the Delegates and Alternate Delegates to the AMA. The Board meets quarterly, although special meetings may be called when indicated. The members of the Board are all volunteers who give freely of their time on your behalf.

KMA continues to achieve significant accomplishments on behalf of its members, some of which will be highlighted in this report. Of all doctors in Kentucky who are eligible for active membership, 71% are members. That compares favorably to other state associations, where the national average is 44%. Nonetheless, it is unfortunate that 29% of the physicians in Kentucky are not part of KMA. It is our job, as those to whom the responsibility of the leadership of the Association has been entrusted as Delegates and Board members, to cause our nonmember colleagues to join us in our efforts on behalf of the profession. To remain effective we must remain united. While we may disagree on specific issues, we will always focus our combined efforts on what is best for our patients and our profession.

Medicine's collective strength was the basis of a major successful effort by KMA to overturn the provider tax, which expired this year. A legacy of the administration of Governor Brereton Jones, the tax cost Kentucky physicians an estimated \$44 million per year. The repeal of the tax and the restoration of Medicaid funds totaling \$104 million over two years were significant and were due to the efforts of KMA—not a bad return on investment for the average member.

Medicaid managed care continues to be carefully followed by your Board. Cabinet for Human Services Secretary John Morse attended Board meetings to discuss regional partnerships and the Kentucky Children's Health Insurance Program (KCHIP). The Committee on Medicaid Managed Care continuously monitors and reports to the Board on developments in the partnerships. KMA representatives have been in several meetings with the Governor and other administration officials to express KMA's concern with the partnership concept, particularly as it affects the rural areas. The Patton Administration, however, remains committed to the development of Medicaid Regional Partnerships statewide.

Last year Past President Ken Peters, MD, initiated KMA's first Strategic Plan. The House adopted the plan and the Board was given the responsibility for its implementation. A full report on those activities are included as Addendum A of this report. One key strategy was to provide local educational opportunities to members in their local communities. This was identified as a high priority in our survey of the membership. As a result, educational offerings on coding, corporate compliance, managed care, the Stark Law, audits and risk management, and how to get started in medical practice were offered across Kentucky. Over 480 physicians and office staff attended. Members of your Board of Trustees made presentations to 20 hospital medical staff meetings as of this report and five more are scheduled between late July and September. Major efforts are also underway in legislative activities, membership recruitment and retention, interaction with the public, and continuing education. I encourage Delegates to read Addendum A that provides a comprehensive report on the implementation of the Strategic Plan.

This year, a major insurance carrier introduced a new tactic to step up harassment of physicians called the "all products" clause or, more accurately,

"all or nothing" clause. This clause requires, as a condition of participation in the carrier's health plan, that a physician agrees to participate in every plan a carrier offers, both now and in the future. As a result, a Louisville IPA terminated its agreement with the carrier. The carrier then told their insured they would have to find new physicians if their current physician refused to participate under the "all or nothing" provision. The Department of Insurance negotiated an interim agreement, which temporarily allows patients to remain with their physician until their plan is renewed or March 2000, whichever comes first.

Since the Nevada Insurance Commissioner had earlier ruled "all or nothing" clauses were coercive and therefore violated the Nevada Unfair Trade Practices Act, which mirrored Kentucky's Unfair Trade Practices Act, Kentucky's Insurance Commissioner was asked by KMA to render a similar ruling. To date, the Commissioner has taken no action.

In the meantime, KMA, Jefferson County Medical Society, and American Medical Association representatives met to develop a strategy to deal with this issue which includes educating members about the inherent unfairness of all or nothing clauses and developing legislation to make such clauses clearly illegal in Kentucky. Passage of additional legislation may prove to be a major undertaking that will require the efforts of all Kentucky physicians.

Alternative therapy has become a greater issue for many physicians. The 1998 Kentucky General Assembly enacted HB 160, which established a Committee on Alternative Therapy to study the issue and report back to the General Assembly in 2000. Bob M. DeWeese, MD, was appointed Vice Chair of the committee which has several physician members including the Deans of the medical schools, and Don Swikert, MD, from the Board of Licensure. That body met several times and KMA testified before it once. KMA also surveyed Kentucky primary care physicians regarding their experience and attitudes about alternative therapy. The results were shared with the committee and reported to the KMA membership through the *Journal*.

A report on the Legal Trust Fund is included annually in the Chair's report. Expenditures of \$4,719 were made during the past year. The Fund's current balance as we prepared this report was \$425,270.

This has been an atypical non-legislative year as many significant issues have been addressed. Only a small part of what has been accomplished on behalf of the membership is included in this report. A summary of KMA activities to implement actions adopted by the 1998 House of Delegates is attached to this report as Addendum B.

The following summary of the Board meetings is designed to provide a quick review of your Board's activities this year. Routinely, the Board meeting begins on Wednesday night and is completed on Thursday morning. Complete minutes of all Board meetings will be provided to Reference Committee A.

Summary of Board Meetings

First Meeting, September 24, 1998

The KMA Board of Trustees held its reorganizational meeting for the 1998-99 Association year on September 24, 1998. Acting Chair William P. VonderHaar, MD, introduced the newly elected members of the Board and the new officers. Harry W. Carlross, MD, Paducah, has been named President-Elect, and Donald R. Neel, MD, Owensboro, was elected Vice President. Following his election, Dr. Neel vacated his position as 2nd District Trustee. Alternate Trustee David A. Watkins, MD, Henderson, assumed the 2nd District Trustee position. Newly elected Trustees were Uday V. Dave, MD, Madisonville, 3rd District, and Baretta R. Casey, MD, Pikeville, 14th District.

The Board elected the Executive Committee members to serve with the President, President-Elect, Vice President, and Secretary-Treasurer for the 1998-99 KMA year. J. Gregory Cooper, MD, Cynthiana, was reelected Chair, Board of Trustees, and Meredith J. Evans, MD, Middlesboro, was elected Vice Chair of the Board. Kenneth R. Hauswald, MD, Ashland, and Thomas E. Bunnell, MD, Crestview Hills, were named as Trustees-at-large.

Five physicians were elected by the House of Delegates to serve on the 2000 Nominating Committee. Members were: Barbara A. Phillips, MD, Lexington, Chair; David E. Bybee, MD, Louisville; Linda Mumford, MD, Owensboro; J. Roger Potter, MD, Ashland; and Scott A. Watkins, MD, Henderson.

Second Meeting, November 18-19, 1998

The KMA Board of Trustees met in regular session on November 18-19, 1998, at the KMA Building in Louisville. The Board members heard reports from

Don R. Stephens, MD, President; William P. VonderHaar, MD, Secretary-Treasurer; John Strosnider, OD, Dean, Pikeville College of Osteopathy; Preston P. Nunnelle, MD, Kentucky Board of Medical Licensure; Robert Woods, MD, Chair, KEMPAC Board of Directors; Donald C. Barton, MD, Senior Delegate to the AMA; and Richard F. Hench, MD, Chair of the Kentucky Medical Insurance Company Board of Directors.

The Board appointed two committees, the Ad Hoc Committee on Cardiovascular Services, chaired by Robert R. Goodin, MD, Louisville; and the Committee on Managed Care, chaired by William B. Monnig, MD, Edgewood. Kenneth R. Hauswald, MD, Ashland; Eugene H. Shively, MD, Campbellsville; and Robert C. Hughes, MD, Murray, were appointed to the KMIC Board Nominating Committee.

The Board adopted Agenda B to implement all actions of the 1998 House of Delegates. In addition, recommendations for implementation of the KMA Strategic Plan were adopted.

Reports were given by the Committees on National and State Legislative Activities, the Public Education Committee, Physician Advisory Committee to Health Kentucky, Committee on Community and Rural Health, and the KMA/KMIC Joint Board Liaison Committee.

It was noted that the 1999 Annual Meeting will be held in Lexington, September 26-30.

The next meeting of the KMA Board of Trustees was scheduled for April 14-15, 1999, at the KMA Building.

Third Meeting, April 14-15, 1999

The KMA Board of Trustees met in regular session on April 14-15, 1999, at the KMA Building in Louisville. The Board members heard reports from Don R. Stephens, MD, President; William P. VonderHaar, MD, Secretary-Treasurer; Danny M. Clark, MD, President, Kentucky Board of Medical Licensure; Donald C. Barton, MD, Senior Delegate to the AMA; Richard F. Hench, MD, Chair of the Kentucky Medical Insurance Company Board of Directors; Rice Leach, MD, Commissioner, Department for Public Health; KEMPAC Board of Directors; and Mrs. James Crase, President, KMA Alliance.

Top recruiters for the KMA Member-Get-A-Member Campaign were recognized. Baretta R. Casey, MD, Pikeville; Harry W. Carloss, MD, Paducah; James A. Wright, MD, Louisville; and the Fayette County Medical Society each received a laptop computer for recruiting ten or more new members. Thirteen physicians received a leather attaché for recruiting at least one new paid member. The campaign generated 68 new KMA members.

Cabinet for Health Services Secretary John Morse reported on the progress of the Medicaid partnerships, the KCHIP program, and the UNISYS contract renewal negotiations.

The Board of Trustees adopted the budget for fiscal year 1999-00. In further action, the Board approved the nominees for election to the KMIC Board of Directors: William B. Monnig, MD, Edgewood, and William P. VonderHaar, MD, Louisville.

Richard Miles, MD, Russellville, was appointed to the Physician Advisory Committee to Health Kentucky; and Janet M. Connell, Administrator, Nephrology Associates of Kentuckiana, was named to the Committee on Managed Care. Wally O. Montgomery, MD, Paducah, was nominated for reappointment as KMA's representative on the Kentucky Hospital Association Board of Trustees.

Additional reports were given by the Committee on National Legislative Activities, the Committee on State Legislative Activities, the Public Education Committee, the Committee on Child and School Health, the Committee on Physical Education and Medical Aspects of Sports, the Ad Hoc Committee on Cardiovascular Services Network, the Committee on Community and Rural Health, and the Council for Continuing Medical Education.

The Board also heard information on membership; the Annual Meeting; and communication activities including practice management seminars, trustee district meetings, and hospital medical staff meetings.

It was noted that the KMA Board of Trustees would hold its next regular meeting on August 4-5, 1999, at the KMA Building.

Fourth Meeting, August 4-5, 1999

The KMA Board of Trustees met in regular session on August 4-5, 1999, at KMA Headquarters Office in Louisville.

KMA President Donald Stephens, MD, reported on recent meetings with the Kentucky Hospital Association and noted the final repeal of the provider tax.

Donald C. Barton, MD, Senior Delegate to the AMA, reported on the AMA Annual Meeting, noting that collective bargaining was the main topic of discussion. Doctor Barton also reported on the Washington visit in June and patient protection legislation being debated in the US Senate and House.

Additional reports were presented by William P. VonderHaar, MD, Secretary-Treasurer; William B. Monnig, MD, Immediate Past Chair, KEMPAC Board of Directors; Preston P. Nunnelle, MD, Kentucky Board of Medical Licensure; and Rice Leach, MD, Commissioner for Public Health. The Board also heard reports from the Ad Hoc Committee on Tobacco Settlement Funds and the Ad Hoc Committee on Cardiovascular Services.

The Board voted to include a \$10 voluntary assessment for the Legal Trust Fund with the 2000 dues billing.

Appointments were made to the KEMPAC Board of Directors, Kentucky Board of Medical Licensure, and the *Journal* Editors Board; and a Judicial Council nominee was approved.

An update was given on the Annual Meeting, nine resolutions were approved for presentation to the House of Delegates, and action was taken on 27 committee reports.

The next meeting of the Board was scheduled for Sunday, September 26, 1999, during the KMA Annual Meeting.

Executive Committee

The KMA Executive Committee meets between sessions of the full Board to guide the day-to-day operations of the association and to research and make recommendations to the Board of Trustees on issues of major concern. The Executive Committee is composed of eight officers and trustees and they met on five occasions this past associational year. They are truly dedicated to the profession.

Quick Action Committee

Four officers comprise the Quick Action Committee, the President, President-Elect, Board Chair and Secretary Treasurer. In addition, during legislative sessions the group also includes the Chair and Vice Chair of our State Legislative Activities Committee. The Legislative Quick Action Committee held three meetings with officers of the KMA this year to discuss issues of mutual interest. This ongoing communication is vital in today's rapidly changing environment.

Ad Hoc Committees

There were two ad hoc committees of the Board working on projects this year. Detailed reports of the Ad Hoc Committee on Tobacco Settlement Funds and the Ad Hoc Committee on Cardiovascular Services appear elsewhere in this book. The recommendations made by the Ad Hoc Committee on Tobacco Settlement Funds were adopted by the Board and are recommended to the House for adoption.

Closing Comments

Serving as Board Chair has been a singular experience and I sincerely thank members of Board, Executive Committee, and Quick Action Committee for their time and attentiveness to the business of KMA and for the courtesy extended to me as Chair. These colleagues are all volunteers who give freely of their time away from their practice to work on behalf of physicians in Kentucky. They have the same practice pressures and concern with time away from home and family as all of us, but they still find a way to serve the profession with their only reward being that they are doing the right thing. It has been an honor to serve with them. I'd also like to acknowledge, with gratitude, the excellent work of the staff.

J. Gregory Cooper, MD
Chair

Addendum A

KMA FUTURE SEARCH

Recommendations For Implementation

Introduction

On May 27 and 28, 1998, 29 physician members of the Kentucky Medical Association, KMA staff, and a representative of the KMA Alliance convened in Shakertown, Kentucky, to launch KMA's first long-range strategic planning process. A number of major themes and priorities emerged from the Shakertown deliberations. Major goals were identified



and adopted by the KMA House of Delegates. The Board of Trustees directed KMA staff to take the information developed at Shakertown and formulate recommendations for prioritizing the goals and implementation strategies for initial action. The Board also recognized that, in a five-year plan, not all suggested activities could be carried out immediately. In addition, many of the activities recommended in the Strategic Plan are already ongoing activities of the Association.

It is recommended, for implementation purposes, that four of the goals be combined into two. The goal "continue efforts to achieve tort reform and serve as a resource for medical legal issues" was combined with the goal, "ensure an effective year-round governmental program and seek a balanced partnership with government." Any activities to achieve tort reform and serve as a resource for medical legal action will likely be carried out through the legislative process. Similarly, the goal of "fostering outcomes-driven quality of care across the state in the next five years" has been combined with the goal "to position KMA to be a more effective leader and advocate influencing the managed care environment and serve as a referral source of information for practicing physicians."

The following outlines recommended priorities, rationale, and recommendations for action.

GOAL 1: Maximize physician participation in organized medicine by enhancing services and facilitating better communication to members and targeting nonmembers for outreach. Work towards a 90% membership rate within five years.

RATIONALE: The level of physician engagement directly affects the ability of the KMA to influence activities across all health care policy domains and to shape the future of medicine. Membership recruitment and retention must occur if any of the efforts of KMA are to be effective. Membership is the essence of KMA's existence.

RECOMMENDATIONS:

Enhance and Expand Continuing Medical Education opportunities. The survey of the membership indicated that members expect KMA to provide timely information on business and practice issues. It is recommended that KMA develop and provide course curricula of continuing education programs across the state. KMIC currently presents educational opportunities carrying Category I CME credit, as well as premium discounts for KMIC insured, which could be combined with KMA programs.

- **Coding and Corporate Compliance Seminars presented in London, Bowling Green and Paducah.** A managed care seminar was done in Louisville, and "Stark Law" programs presented by Mr. Cronan in Louisville and Lexington. "How to Get Started in Medical Practice" will be given in Louisville March 23. Seminars on Audits and Risk Management are scheduled for April 20-21-22 in Louisville, Lexington and Covington. Seminars on Coding and Corporate Compliance are scheduled for the same locations May 11-12-13. Seminars on Managed Care and Corporate Compliance are scheduled for Somerset, Pikeville, and Louisville or Paducah, June 1-2-3. Also offering compliance seminars to anyone interested. 480 physicians and staff attended.

A similar series of courses for late fall are in the early planning stages.

A video "commercial" would be developed and shown in conjunction with CME offerings to provide KMA an opportunity to share the vast array of activities in which the association is involved. The video will serve to assist in retaining members and recruiting nonmembers. Application and membership documents would be presented to attendees and appropriate follow-up would occur.

- A 6-minute "video report" has been produced for showing at seminars, trustee district meetings, and hospital medical staff visitations. The Public Education Committee and KMIC provided funding for the videotape.

Initiate KMA Board/Hospital Medical Staff visitation program. If each KMA Board member attends and makes brief comments at four medical staff meetings a year, virtually every medical staff could be visited in a year's time. Staff would coordinate the visitation program, and hospitals assigned based on geographic convenience to the trustee.

- Hospital medical staff visits were scheduled and attended by Board members at 25 hospitals.

The Public Education Committee should develop a short videotape about KMA that would be shown at these meetings. The trustee would

make a short presentation on an issue of timely importance.

- **Same video is used as above.**

KMA and KMIC may offer continuing medical education opportunities, as an afternoon or evening program.

Member-get-a-member campaign. Encourage physicians to contact nonmember peers and urge them to become members. Reminders will be sent through individual correspondence and the *Communicator* to build awareness of the project and generate enthusiasm for participation.

- **Member-Get-A-Member Campaign concluded March 1. 50 paid, another 17 applications are pending. 23 new AMA members. 30 recruiters participated in the program.**

The Membership Task Force should be asked to look at KMA's current communication vehicles to determine how they might be improved for readability and attractiveness.

County Society Meetings. Offer nonclinical CME programs at the county society level.

- **Corporate compliance seminars are available to county societies on request.**

Personal Visits to Nonmembers. One-on-one personal visits will be made to nonmembers as is practical to recruit membership.

Membership Roster. Twenty county medical societies have more than 50 members. On a pilot project basis, develop and distribute a KMA membership roster for targeted counties. Survey results indicated that members are interested in recognizing nonmembers. If the trial is successful, the next step would be to develop a statewide membership directory for counties where directories are not currently provided.

- **Contact underway with roster production companies. Counties with more than 50 members are being contacted for determination of interest.**

Mini Internship Programs. Jefferson, Fayette, and Northern Kentucky Medical Societies now offer mini internship programs during the year. It is recommended that KMA assist a limited number of county societies in offering mini internship opportunities.

- **Public Education Committee stands ready to help in assisting mini internships in small counties.**

KMA will continue its ongoing membership recruitment and retention efforts, which are carried out on a routine basis.

- **42% of new members in 1999 came through this mechanism.**

GOAL 2: Ensure an effective, year-round government program and seek a balanced partnership with government. Continue efforts to achieve tort reform and serve as a resource for medical legal issues.

RATIONALE: The legislative and governmental advocacy functions are the top KMA priority among those members surveyed and are also highly ranked by Kentucky opinion leaders. KMA members perceive a continued high level of government involvement in the coming decade and wish to exercise influence in leadership in all health care policy domains. The complex legal environment continues to be a significant practice variable for physicians, and therefore, an advocacy concern for KMA.

RECOMMENDATIONS:

Pursue legislative goals as directed by the House of Delegates, and develop and implement legislative strategies to achieve short- and long-term legislative priorities.

- **Legislative Goals and Strategies:**

Tort Reform—Support amendment to Kentucky Constitution or federal legislation to limit non-economic component of medical liability awards. Support amendment to ERISA law making managed care employees and physicians making decisions that result in patient injury or death to be held legally responsible for their decisions. Establish arbitration boards to resolve disputes without going to court, and limit level of contingency fees paid to attorneys in medical malpractice awards. Oppose legislation expanding the nature and/or extent of recoveries allowable under wrongful death law or other proposals that expand recovery in medical liability.

Patient Protection/Provider Fairness—The General Assembly should build on reforms embodied in HB315 (1998) by making decision-makers employed or under contract to managed care plans accountable for determinations resulting in injury or death to plan enrollees. Enact legislation providing independent, external appeals mechanisms for managed care plans and provisions to require insurers to pay

physicians within 15 days for a clean, electronically submitted claim. Continuity of care in the managed care environment, especially where terminally ill patients are involved, warrants special attention. Establish mechanism to assure gravely ill patients are not cut off from physicians with whom they have established long-term relationships.

Public Health—Work with the Commissioner of Public Health and allied health organizations to improve health and environment of the Commonwealth. Discourage use of tobacco among all Kentuckians and support legislation to prevent children's access, purchase, and use of tobacco. Drug, alcohol, and domestic abuse preventive programs and treatments should be available. Enact and enforce legislation to require use of helmets by motorcyclists and bicyclists and prohibit minors from riding in open vehicles on state highways. Stringently enforce driving under the influence laws. Support mandatory health education (K-12) and sex education beginning in grades 5-7.

Medical Education and Research—Support enhanced financing of medical education and research by Government and private resources. Insurance companies and managed care plans should adequately compensate medical schools for the additional costs of training medical students, and residents.

Non-Physician Health Care Providers—Non-physician practitioners should not serve as gatekeepers, perform surgery, or be granted authority to deny access to medical services. Work to provide a forum for the resolution of conflicts that exist between professions on scope of practice issues. Enhancement of practice acts by "legislative fiat" undermines quality and increases cost, and should be opposed.

Enhance and influence health care policy decisions in the governmental arena, through strengthened regulatory oversight, by monitoring and improving relationships with appropriate administrative and legislative agencies.

- COSLA has effectively monitored interim legislative committees, and addressed governmental regulatory and administrative proposals. COSLA produced legislative handbooks, reports, and weekly legislative bulletins to keep members informed and capable of working with locally elected officials.

Promote physician and spouse candidacy, and encourage financial and personal support for candidates who share medicine's philosophy. Foster political participation by educating physicians, spouses, and staff through instruction and information. In addition, promote KEMPAC membership among physicians and spouses as the political arm of organized medicine in Kentucky.

Reevaluate and develop legislative priorities and strategies on an annual basis, and provide for continual transition of KMA leadership and staff.

- Reevaluating and developing legislative priorities and strategies is an ongoing process. Oversight by COSLA, Legislative Quick Action Committee, Board of Trustees, and the House of Delegates on an annual basis, provides continuity and makes KMA's legislative program and priorities accountable. The Legislative Quick Action Committee meets weekly in Frankfort when the General Assembly is in Session with KMA lobbyists to develop strategy, establish priorities, and direct the overall lobbying effort. Communications is on going with appropriate Specialty Societies when legislation is introduced specific to their practice. The Board of Trustees has provided for continuity of the legislative leadership by appointing a Vice Chair of COSLA. Executive Vice President has employed additional staff to begin an orderly internal transition in the Legislative Department.

GOAL 3: Preserve the doctor/patient relationship and emphasize the goal of "putting the patient first" as central to the integrity of medicine.

RATIONALE: The rapid changes in health care delivery have introduced conflicts into the fundamental doctor/patient relationship, and protection of this relationship is critical for the practice of the profession. Maintaining the doctor/patient relationship is central to the practice of medicine and to the purpose of KMA.

RECOMMENDATIONS:

Request the Public Education Committee to develop and implement a patient satisfaction survey, which would be offered to the membership at a reasonable cost.

- The committee was also directed by Future Search to develop a document regarding questions patients are encouraged to ask physicians. Staff reported that Clayton Scroggins Company declined a request to obtain a copy of a survey they had developed. Staff will continue to research this project.

Develop CME offerings to assist members in enhancing their communication skills with patients.

- Consultants with expertise in this area are being sought and evaluated. At least one seminar is in discussion stage.

Maintain and/or expand current patient protection provisions.

- Referred to COSLA.

Provide CME practice management programs to advise members on billing guidelines and reporting requirements.

- Implemented as part of continuing education opportunities.

Enlist the Public Education Committee, the Kentucky Association of Medical Assistants, and the Kentucky Medical Group Management Association to develop a document related to questions patients are encouraged to ask. While physicians want to do what's best for patients, on the other hand, patients may be intimidated, anxious, or unsure of what to ask their physician. This document would provide information to patients to enhance the physician/patient encounter.

GOAL 4: Position KMA to be a more active leader and advocate in influencing the managed care environment and to serve as a clearinghouse (referral source) of information for practicing physicians. Foster outcomes-driven quality of care across the state in the next five years.

RATIONALE: The percentage of health care services affected by managed care practices is expected to continue increasing in the next five years, along with the possibility of new delivery systems. These changes must be a top priority for KMA's advocacy and education efforts on behalf of physicians. Physicians are the appropriate leaders in the movement to improve quality of health care and evaluate treatment protocols, and these issues affect the basic practice environment of all KMA members.

RECOMMENDATIONS:

Open and continue dialogue with payers as indicated (insurance companies, chambers of commerce, business groups, employers, unions, etc.) to advocate on behalf of physicians and their patients.

- Quick Action Committee met with several association representatives to discuss issues of mutual importance and that dialogue is continuing. Officers and staff having daily communication with representatives of government, insurance, allied health organizations, business, etc.

- Managed Care Committee has discussed inviting Medical Directors for discussion of issues.

Increase CME offerings on contract review, practice management, and other business-related topics.

- Implemented as part of continuing education opportunities.

Offer "mini" contract review sessions to county medical societies. Sessions would be abbreviated, one-page "red flag" review summaries provided to the county societies by staff. Others topics may be offered in the future.

Monitor/implement collective negotiations development. Provide educational sessions for members once federal agencies have indicated what courses can safely be pursued in terms of collective negotiations.

- Receive periodic updates on AMA progress in this area. Exploring state statutes that may provide ability to collectively negotiate.
- Having educational session at 1999 Annual Meeting.

Combine KMA Physicians Plan Board membership and the Committee on Insurance and Prepayment Plans into a Committee on Managed Care. Include as members, nonphysicians from business, medical group managers, and/or other appropriate entities. The mission of the committee would be to discuss Kentucky payer policies; meet with representatives of payers; discuss payer contracts; discuss and suggest training needs and priorities for physicians on business issues; and serve as a forum for independent practice associations to discuss issues of common interest. From time to time, medical directors of HMOs and PPOs should be invited to discuss quality and cost issues.

- These two groups have been combined into a new Managed Care Committee.



KMAPP should be dissolved as a corporation. Members of the Committee on Medical Insurance and Prepayment Plans and the members of the Board of Directors of KMAPP could comprise part of the membership of the new Committee on Managed Care.

- **KMAPP Board of Directors voted to dissolve the company on January 14, 1999.**

GOAL 5: Take a proactive role in defining and responding to the educational and ethical challenges arising from the new frontiers of medical knowledge.

RATIONALE: Emerging research in genetics and other "new frontier" arenas introduce significant ethical challenges that affect patient care and, thus, physicians. Medicine is one of the few professions with an evolving code of ethics. Changes in practice arrangements test the validity of medicine's ethics daily. Physicians are the best source to determine ethical behavior and should be in the forefront in advocating enforcement of ethical behavior as one of, if not the activity, giving the profession credibility.

RECOMMENDATIONS:

Develop and present continuing medical education offerings on ethics of genetic engineering/technology challenges to include confidentiality of patient genetic information.

Develop CME Offerings on the ethics of managed care and present, in conjunction with medical schools, when possible.

The Scientific Program Committee should focus on the subject of technology for the 1999 or 2000 Annual Meeting and periodically thereafter.

- **Referred to Scientific Program Committee.**

GOAL 6: Establish new connections and strengthen existing physician ties with the broader health care community and the public at large.

RATIONALE: The effectiveness of physician leadership across all health care policy domains is directly linked to the ability to communicate with and engage in cooperative activities with the many other organizations and populations who also have a stake in Kentucky health care.

RECOMMENDATIONS:

Encourage and assist small county societies with mini internship programs.

Track and promote free medical care programs and achievements of physicians across the state. Vehicles such as the media, tapes, cable TV, and web pages may be utilized to recognize and communicate physician contributions to the broader community.

- **The American Medical Association has undertaken a national survey of physician-led programs that reach underserved populations. Initial results indicate the number and quality of programs provided by Kentucky physicians are far ahead of other states.**

- **Special issue of MediScope devoted to this subject.**

Seek to improve and maintain relationships with media.

Refer recommendations to the Public Education Committee for further development.

Involve and focus on young, minority and female physicians in public education efforts. There are a number of opportunities to include younger members in activities such as the Adopt-a-Physician Program, presentations on domestic violence, etc. Work closely with the University of Kentucky, the University of Louisville and Osteopathy Schools in developing educational programs for high school, junior high school, and elementary school children taught by third and fourth year medical students. Topics include smoking prevention, drug prevention, STD awareness, etc.

- **The Committee on Child and School Health and Dean Wilson, University of Kentucky College of Medicine, are exploring opportunities to address specific health issues in the classroom using medical students, resident physicians, and practicing physicians.**

Continue interaction with entities such as the Kentucky Chamber of Commerce, Blue Cross/Blue Shield, KHA, KNA, and other organizations.

- **This is an ongoing basic activity of leadership and staff.**

Continue and enhance existing projects of standing KMA committees and Alliance.

- **This is an ongoing basic activity of leadership, the Alliance, committees, and staff.**

Committee on Complementary and Alternative Therapies to continue study and develop information on Complementary and alternative therapies.

- **This is an ongoing responsibility of the committee.**

GOAL 7: Achieve universal access to health care for Kentuckians within five years.

RATIONALE: Advocating for the health care of all the community's citizens is a fundamental role for physicians to play and concern about medically underserved populations continues to rank highly among priorities identified by both Kentucky opinion leaders and KMA members.

RECOMMENDATIONS:

We believe that universal access to health care presently exists. Universal coverage is the greater concern. Universal access is an important issue and one that KMA, as an organization, continues to address through the Kentucky Physicians Care Program, other local medical society initiatives and legislative activity

CONCLUSION

Examination of the rich diversity of ideas, suggestions, and thoughts embodied in this strategic plan brings one to the rapid conclusion that there are many more worthwhile ideas, goals, and objectives than KMA will ever have the resources, staff, and dollars to implement. However, the process has expanded the boundaries of how members and staff perceive the association and the "Future Search" project clarifies the need to expand KMA's participation, influence, and communication with other entities and partners. Some proposals outlined may not work as intended, or at all. Others may generate positive results and programs and unexpected projects.

KMA should continue to periodically convene a strategic planning session to reevaluate its programs and plan for the future.

Addendum B

SUMMARY OF IMPLEMENTATION OF ACTIONS

1998 HOUSE OF DELEGATES

(Addendum to the 1999 Report of the Chair, Board of Trustees)

MEMORIAL RESOLUTIONS

1. **Memorial to Krishan K. Arora, MD—Adopted**

ACTION: Send appropriately stylized copy of resolution to family, along with letter from President. (*Sent 1/26/99*)

2. **Memorial to Ralph C. Morris, MD—Adopted**

ACTION: Send appropriately stylized copy of resolution to family, along with letter from President. (*Sent 1/26/99*)

3. **Memorial to Debra L. Zukof, MD—Adopted**

ACTION: Send appropriately stylized copy of resolution to family, along with letter from President. (*Sent 1/26/99*)

TRIBUTE RESOLUTIONS

4. **Tribute to Women in Medicine—Adopted**

A. 1st, 4th, and 6th Resolveds RE: tribute to women, urge women to become involved, urge women to join Women Physicians Congress.

ACTION: Special notice in *Communicator*. (*November '98 Communicator*)

B. 2nd and 3rd Resolveds, RE: Ardis D. Hoven and Nancy W. Dickey.

ACTION: Send appropriately stylized copies of resolutions along with letter from President. (*Sent 1/26/99*)

5. **Tribute to William B. Monnig, MD—Adopted**

ACTION: Send appropriately stylized copies of resolution along with letter from President. (*Sent 12/10/98*)

6. **Tribute to Bob M. DeWeese, MD—Adopted**

ACTION: Send appropriately stylized copies of resolution along with letter from President. (*Sent 12/10/98*)

7. **Tribute to Nancy W. Dickey, MD—Adopted**

ACTION: Send appropriately stylized copies of resolution along with letter from President. (*Sent 1/26/99*)

CONSTITUTIONAL AMENDMENTS

8. **1998 Amendment**

RE: Residents, medical school deans, et al, as members of House.

ACTION: Amend Constitution. (*Printed 6/17/99*)

9. **1999 Amendment**

RE: Pikeville Osteopathic School Dean to be member of House

ACTION: Send to county societies and delegates for 1999 Annual Meeting vote. (*Sent 7/9/99*)

REFERENCE COMMITTEE A

10. **Report of the President (1)—(Consent Calendar) Filed**
Entire report.
ACTION: Letter of thanks from Board Chair. (*Letter dated 11/25/98*)
11. **Report of the President, Alliance (2)—(Consent Calendar) Filed**
Entire report.
ACTION: Letter of thanks from Board Chair. (*Letter dated 11/25/98*)
12. **Report of the Physician Advisory Committee to Health Kentucky (13)—Adopted**
A. Reports Book, p. 13.3, Recommendation #1, RE: Continue endorsement of program.
ACTION: Policy statement; no action necessary.
B. Reports Book, p. 13.3, Recommendation #2, RE: Encourage physician participation in program.
ACTION: *Communicator* article encouraging participation. Periodic solicitation of members as recommended by the Advisory Committee. (*December '98 Communicator*)
C. Reports Book, p. 13.3, Recommendation #3, RE: KMA continue endorsement based on certain contingencies.
ACTION: Refer to Physician Advisory Committee to Health Kentucky. (*April 14, '99 Minutes from Physicians Advisory Committee to Health KY*)
13. **Resolution 105—KMA Annual Meeting Dates (Jefferson County Medical Society)—Adopted**
RE: Resolved, that the Kentucky Medical Association not schedule future KMA Annual Meetings on the Jewish High Holy Days.
ACTION: Refer to staff as part of Annual Meeting criteria used in Annual Meeting site selection.
14. **Resolution 112—Health System Reform (Fayette County Medical Society)—Adopted as Amended**
RE: Resolved, that the Kentucky Medical Association shall direct the Board of Trustees to produce an updated policy/guidelines statement in 1999 on Health System Reform. The Board shall consider but not be limited to the following issues in the policy/guidelines statement [there is a long list of general issue statements included in the resolution, which will be referred to the committee].
ACTION: Refer to Committee on State Legislative Activities. (*COSLA adopted revised policy on health system reform—Minutes 3/4/99.*)
15. **Resolution 116—KMA Strategic Plan (Board of Trustees)—Adopted as Amended**
RE: Resolved, that the House of Delegates endorse the goals as developed through the Strategic Plan and support the Board of Trustees as it works to implement, periodically review, and report the progress of the KMA Strategic Plan.
ACTION: Include, as part of the Board Chair's report to the House of Delegates, information on implementation of the plan, as indicated. (*Plan Implementation added to Chair's report*)
16. **Resolution 121—Observer Status for Kentucky Academy of Physician Assistants (Board of Trustees)—Adopted**
A. First Resolved: that the Kentucky Academy of Physician Assistants be granted official observer status at all regular and special meetings of the House of Delegates through one designated representative.
ACTION: Send letter of invitation from Speaker of House to President of Kentucky Academy of Physician Assistants, asking for designation of Official Observer. (*Letter dated 1/14/99*)
B. Second Resolved: that such observer receive all mailings, publications, and materials received by all regular delegates and be required to register for each meeting and wear an appropriate badge, but may not take part in House proceedings.
ACTION: Add observer to list of those receiving House of Delegates mailings. (*Letter dated 2/24/99*)
C. Third Resolved: that this specific appointment and process of conduct be adopted as a standard procedure of this House of Delegates.
ACTION: Include procedure as standard operating procedure for House of Delegates. (*Added to Policy Manual*)

REFERENCE COMMITTEE B

17. **Resolution 106—Credentialing of Nuclear Medicine Technologists (Jefferson County Medical Society)—Referred to the Board of Trustees for further consideration**
RE: Resolved, that KMA endorse the state credentialing of nuclear medicine technologists by the Cabinet for Health Services.
ACTION: Refer to COSLA. (*Motion adopted that Until KMA receives a formal request from the Nuclear Medicine Technologists and reviews the actual proposal, KMA refrain from commenting - Minutes 3/4/99*)
18. **Resolution 107—Guidelines for Pap Smear Review in Litigation: KMA Endorsement of College of American Pathologists Guidelines (Fayette County Medical Society)—Adopted**
A. First Resolved: that KMA support and endorse the official College of American Pathologists Guidelines for Review of Pap Smears in the Context of Litigation or Potential Litigation.
ACTION: KMA policy statement; letter to College of American Pathologists. (*Letter sent 11/9/98*)
B. Second Resolved: Kentucky Delegates to the AMA work to obtain AMA endorsement of these guidelines.
ACTION: Refer to AMA Delegation. (*Letter dated 11/9/98. Resolution submitted to AMA House at '98 Interim meeting. College of Pathologists was sponsor, KMA cosponsor. House voted to refer resolution with no certain date for report.*)
19. **Resolution 115—Physician Education on End-of-Life Care (Board of Trustees)—Adopted**
Resolved: Inform Kentucky physicians of the AMA "Education for Physicians on End-of-Life Care" and its educational opportunities.
ACTION: Inform through *Communicator*, Journal (*December '98 Communicator, February '99 Journal*)
20. **Resolution 109—Physician Assistants (McCracken County Medical Society) Resolution 124—Physician Assistants (Board of Trustees)—Adopted 124 in lieu of 109**
A. First Resolved: KMA House reaffirm support for certification of Physician Assistants by Kentucky Board of Medical Licensure.
ACTION: Reaffirm KMA policy. (*Added to Policy Manual*)
B. Second Resolved: Medical institution policies for purposes of staff privileges for practitioners be established by the local institution in conjunction with medical staff.
ACTION: KMA policy statement. (*Added to Policy Manual*)
C. Third Resolved: Institutional staff privileges be determined commensurate with an applicant's education, training, experience, and demonstrated current competence; JCAHO standards; and federal, state, and other governmental laws and regulations.
ACTION: KMA policy statement. (*Added to Policy Manual*)
D. Fourth Resolved: Forward copy to Kentucky Board of Medical Licensure, Kentucky Hospital Association, and Kentucky Association of Physician Assistants.
ACTION: 1) Copy of resolution sent to KBML, KHA, and KAPA. (*Letters sent 12/4/98*)
2) Refer resolution to COSLA. (*Resolution accepted by COSLA for information-Minutes 3/4/99*)

REFERENCE COMMITTEE C

21. **Report of Committee on National Legislative Activities (23)—(Consent Calendar) Filed**
RE: Reference Committee Report, page 1, lines 42-43, and page 2, line 1, special thanks to Drs Barton and Montgomery for their efforts in the areas of state and national legislative activities and professional liability insurance.
ACTION: Write letter to Chair noting reference above. (*Letters sent 12/7/98*)
22. **Report of the Committee on State Legislative Activities (24)—(Consent Calendar) Filed**
RE: Reference Committee Report, page 1, lines 42-43, and page 2, line

1, special thanks to Drs Barton and Montgomery for their efforts in the areas of state and national legislative activities and professional liability insurance.

ACTION: Write letter to Chair noting reference above. (*Letters sent 12/7/98*)

23. Report of the Committee on Professional Liability Insurance (25)—(Consent Calendar) Filed

RE: Reference Committee Report, page 1, lines 40-42, express appreciation to author of report for efforts.

ACTION: Write letter to Chair noting reference above. (*Letter dated 12/7/98*)

24. Report of the Committee on Care for the Elderly (26)—(Consent Calendar) Filed

RE: Reference Committee Report, page 1, lines 40-42, express appreciation to author of report for efforts.

ACTION: Write letter to Chair noting reference above. (*Appreciation verbally transmitted at 4/19/99 committee meeting.*)

25. Report of the Public Education Committee (27)—(Consent Calendar) Filed

RE: Reference Committee Report, page 1, lines 40-42, express appreciation to author of report for efforts.

ACTION: Write letter to Chair noting reference above. (*Letter dated 12/8/98*)

26. Report of the Maternal Mortality Study Committee (22)—Referred to the Board of Trustees

RE: Committee Recommendation that KMA initiate legislative action "that mandates maternal deaths be reviewed in a timely fashion and not at the discretion of the hospital in which the death occurred."

ACTION: Letter to the committee chair, noting that:

- 1) KMA opposes mandated peer review (*Letter dated 2/8/99*)
- 2) Recent Kentucky Supreme Court decision makes peer review records discoverable in professional liability cases. (*Letter dated 2/8/99*)

27. Resolution 101—Evaluation & Management Guidelines and Fraud & Abuse Investigation (Daviss County Medical Society)—Adopted as Amended

ACTION: [Note: KMA/AMA have previously complied]

- 1) Refer to the National Legislative Committee for information and follow up. (*Letter dated 12/7/98*)
- 2) Send letter to AMA with copy of resolution. (*Letter dated 11/24/98*)
- 3) Send copy to Kentucky's Delegates and Alternates to the AMA. (*Discussed by Delegation at December meeting*)

28. Resolution 104—Study of Current Antitrust Environment—Adopted as Amended

- A. First Resolved: KMA Board of Trustees consider current antitrust environment.

ACTION: Refer to the Trends Committee for study. (*Letter dated 12/1/98*)

- B. Second Resolved: KMA endorse and support efforts of the AMA.

ACTION: Send copy of resolution to the AMA, with copy to Kentucky Delegates and Alternates to the AMA. (*Referred to AMA Delegation 12/5/98*)

- C. Third Resolved: KMA present an education session at the next Annual Meeting and disseminate information to membership.

ACTION: Present an educational seminar at the 1999 Annual Meeting. (*Scheduled for September 27 at 3:00 pm*)

29. Resolution 117—Gag Clauses (Board of Trustees)—Adopted as Amended

- A. First Resolved: KMA membership be urged to review contracts and report instances of dismissal of physicians from plan participation because of patient advocacy.

ACTION: Articles in *Communicator* and *Journal* (November '98 *Communicator*, December '98 *Journal*)

- B. Second Resolved: KMA report to Kentucky State Insurance Commissioner any health plans that have engaged in these and related activities.

ACTION: Letter to the Insurance Commissioner with copy of resolution. (*Letter sent 2/8/99*)

- C. Third Resolved: KMA make public names of health plans that have gag clauses in contracts or have sanctioned physicians for patient advocacy.

ACTION: Refer to the Committee on Medical Insurance and Prepayment Plans for follow up. (*Referred to Committee on Managed Care 12/22/98. Contracts requested through Communicator and Journal. Article published in Journal with results.*)

- D. Fourth Resolved: KMA consider regulatory, legislative, and legal action.

ACTION: Refer to COSLA and Committee on Medical Insurance and Prepayment Plans for follow up. (*Referred to COSLA 12/9/98—Committee accepted for information. Referred to Committee on Managed Care 12/22/98.*)

30. Resolution 118—Fraud and Abuse (Board of Trustees)—Adopted as Amended

- A. First Resolved: Encourage Cabinet for Health Services to use funds to educate physicians rather than hiring outside companies to investigate and prosecute.

ACTION: Letter to Secretary for Health Services. (*Sent 12/2/98*)

- B. Second Resolved: KMA officially submit protest to the Governor and the Secretary of the Cabinet for Health Services regarding use of outside entities.

ACTION: Letter to Governor, with copy to Secretary for Health Services. (*Sent 12/2/98*)

- C. Third Resolved: KMA oppose all bounty systems in the investigation and prosecution of fraud and abuse.

ACTION: Refer to Technical Advisory Committee on Physician Services—Title XIX and Committee on Medicaid Managed Care. (*Letter dated 12/3/98—TAC monitoring*)

- D. Fourth Resolved: Request the AMA establish a mechanism for collection and review of fraud and abuse investigations of physicians.

ACTION: Refer to the AMA with copies to Kentucky's AMA Delegation. (*Letter dated 11/24/98*)

31. Resolution 120—Sessions of the Kentucky General Assembly (Board of Trustees)—Adopted

- A. First Resolved: KMA opposes the adoption of the "annual session amendment" that would extend times when KGA meets.

ACTION: Article in *Journal* and *Communicator*. (*December '98 Communicator*)

- B. Second Resolved: House urges physicians, their spouses, and staffs to oppose proposed amendment on November general election ballot that expands KGA session.

ACTION: Refer to KMA Quick Action Committee. (*Amendment defeated. 11/18/98 BOT Minutes*)

- C. Third Resolved: KMA communicate and join with other groups in opposing the annual session amendment.

ACTION: Refer to the KMA Quick Action Committee. (*Amendment defeated 11/18/98 BOT Minutes*)

- D. Fourth Resolved: House authorizes Board of Trustees to assist in funding public information programs to educate public and voters on future ramifications and costs to taxpayers if the annual session amendment is adopted.

ACTION: Refer to the KMA Quick Action Committee, Chair of the KMA Public Education Committee, and Chair of the KEMPAC Board of Directors. (*Amendment defeated. 11/18/98 BOT Minutes*)

REFERENCE COMMITTEE D

32. Resolution 102—Outcomes Indexed by Severity (Jefferson County Medical Society)—Adopted as Amended

ACTION: Refer to Committee on Insurance and Prepayment Plans. (*Referred to Managed Care Committee 12/22/98. Ongoing.*)

33. Resolution 108—Patient/Physician Relationship (Fayette County Medical Society)—Adopted as Amended

ACTION: Refer to Board of Trustees. (*First Resolved referred to Committee on Managed Care 11/18/98. Second Resolved—ongoing activity.*)

34. Resolution 111—Universal Access to Health Care (Fayette County Medical Society)—Adopted

ACTION: Refer to Committee on State Legislative Activities. (*Referred 12/9/98. Committee recommended that resolution be amended as follows: Society has an obligation to make access to necessary medical health care available to all of its citizens, regardless of ability to pay.*)

35. Resolution 113—Managed Care (Fayette County Medical Society)—Adopted

ACTION: Refer to Committee on Medical Insurance and Prepayment Plans. (*Referred to the Managed Care Committee on 12/22/98. Committee monitoring.*)

36. Resolution 114—Membership Recruitment (Board of Trustees)—Adopted

ACTION: 1) Refer to Membership Task Force. (Sent letter to membership 12/8/98)
2) Advertise Member-Get-A-Member Campaign in Communicator. (November 1998, January 1999 Communicator)

37. Resolution 119—Insurance Department Enforcement of Late Payment Statute (Board of Trustees)—Adopted

ACTION: Refer to COSLA. (*COSLA adopted motion directing staff to work with LRC on legislation that addresses the issues in the resolution and report back to COSLA at its November 1999 meeting.*)

REFERENCE COMMITTEE E

38. Report of the Committee on Community and Rural Health (36)—(Consent Calendar) Filed

RE: Reference Committee Report, page 2, lines 4-6, thanking authors of reports for their efforts.

ACTION: Letter from Board Chair thanking chairperson and committee members for their work. (*Letter sent 11/3/98*)

39. Report of the Committee on Physical Education and Medical Aspects of Sports (37)—(Consent Calendar) Filed

RE: Reference Committee Report, page 2, lines 4-6, thanking authors of reports for their efforts.

ACTION: Letter from Board Chair thanking chairperson and committee members for their work. (*Verbally transmitted 10/22/98*)

40. Report of the Committee on Child and School Health (38)—(Consent Calendar) Filed

RE: Reference Committee Report, page 2, lines 4-6, thanking authors of reports for their efforts.

ACTION: Letter from Board Chair thanking chairperson and committee members for their work. (*Letter dated 2/8/99*)

41. Report of the Interspecialty Council (40)—Adopted

RE: Committee Recommendation that the Council not be reappointed.

ACTION: Do not reappoint Interspecialty Council.

42. Resolution 103—Medicaid Outpatient Testing (Jefferson County Medical Society)—Adopted as Amended

Reference committee report, p. 2, line 22, and Resolved, RE: seek single standard of care and reimbursement regardless of site of service.

ACTION: 1) Send resolution and letter to Commissioner for Medicaid Services. (*Letter dated 12/3/98*)

2) Refer to Title XIX committee to evaluate progress. (*Letter to Dr George dated 12/3/98*)

43. Resolution 110—Confined Animal Feeding Operations (John A. Patterson MD MSPH)—Referred to the Board of Trustees

Reference committee report, p. 3, lines 2 and 3.

ACTION: 1) Board Chair to advise author of House action. (*Dr Patterson was invited to 4/2/99 Committee meeting where resolution was discussed.*)

2) Refer to Committee on Community and Rural Health to develop independent information, evaluate the issue

and make recommendations to the Board. (*After discussion, resolution was withdrawn - 4/2/99 minutes*)

44. Resolution 122—Vaccine for Children (Board of Trustees)—Adopted

Reference committee report, p. 3, line 11, and Resolveds RE: amend existing federal law and support S 2013 and HR 3794.

ACTION: 1) Refer to Committee on National Legislative Activities to transmit this position to Congressmen and take any other appropriate action. (*Letter dated 12/7/98*)

2) Send copy of resolution to Commissioner, Department for Health Services. (*Letter dated 4/12/98*)

45. Resolution 123—Universal Vaccine (Board of Trustees)—Adopted

Reference committee report, p. 3, line 19, and Resolved RE: consider implementation of University Vaccine Program.

ACTION: Refer to Committee on State Legislative Activities to evaluate and act if appropriate. (*Discussed at 3/4/99 COSLA meeting. Adoption would require biennial funding of \$2 million from the General Assembly. Ongoing*)

Report of the Secretary-Treasurer

The KMA Bylaws provide that the Secretary-Treasurer shall act as the corporate secretary of the Association and have overall supervisory responsibility for receipt and expenditure of funds, oversee property, and provide supervision of operations of the Association on behalf of the Board of Trustees. In practice, these responsibilities have allowed me to become involved and participate in most efforts of the Association. This perspective not only gives an unparalleled view of what KMA does, but also provides for contact with many of the physicians for whom KMA operates and a deep appreciation for the breadth of our profession.

Contained in the materials provided to Delegates are reports of the committees of the Association and the activities of the officers. This material gives an overview of the work that is taking place on behalf of members this year. However, in addition, there are myriad functions that occur as a matter of routine that may never come to the full attention of the membership.

Some examples are KMA's representation in an end-of-life care coalition; work with different organizations on legislative and regulatory changes; participation on state task forces dealing with elderly abuse, breast cancer, and drug and alcohol abuse and prevention programs; coordination with other state medical associations to share information and advocacy efforts on administrative operations; litigation efforts; activities involving medical liability changes, and others. Together with the work of the officers, Board of Trustees, and committees, this depth of involvement on behalf of the profession is gratifying and impressive. I have been privileged to be a part of all of this.

With regard to specific issues, the Association's finances continue to remain in sound condition, and I would direct your attention to the budget and accountant's report that accompanies materials for Delegates. While operating costs continue to rise, as they do in all businesses, careful planning and conservative actions on the part of the Budget Committee and Board of Trustees have produced solid solvency, in spite of a projected deficit.

Obviously, a key to the viability of the Association is membership, and efforts will be renewed in the coming year on the Member-Get-A-Member Campaign. Materials provided elsewhere will give detailed information on this program.

To meet the needs and demands of the profession, a series of seminars was sponsored this year in an effort to extend KMA's services to the membership. These included coding seminars, sessions on corporate compliance, and other topic-specific meetings. Also this year a series of hospital staff meeting visits by KMA Trustees was conducted. In addition to providing information about KMA and current developments, these meetings provide an opportunity for dialogue with members, and the efforts of the Trustees during these sessions is appreciated.

As directed by the House last year and in yet another response to member demand, a special seminar has been scheduled on Monday, September 27, during the Annual Meeting on collective bargaining. KMA Legal Counsel Charles J. Cronan, IV, will provide an update on current developments in this area and Delegates are encouraged to attend.

Two other specific activities occurred this year that are worth your



review. These appear in the form of ad hoc committee reports on the tobacco settlement and cardiovascular services. These reports follow the report of the Chair, Board of Trustees, and deal with specific issues of concern.

This year the Association was pleased to welcome a new executive staff member, Marshall E. White. Marty will be involved in legislative representation and other areas. He joins a capable and committed staff led by our Executive Vice President, Bill Applegate. In my tenure as Secretary-Treasurer and Bill's capacity as the Chief Executive Officer, I have developed an appreciation and respect for his abilities, loyalty, and commitment to KMA. As an example of the dedication of our staff, the six senior members represent over 110 years of experience, and many of our employees have devoted over 20 years to the Association.

I have taken great pleasure, too, in my participation and interaction with the Board of Trustees and our officers. President Don Stephens, President-Elect Harry Carlross, Board Chairman Greg Cooper, and all the members of the Board have provided noteworthy leadership and outstanding representation for KMA, as well as having become good friends.

This will be my last report to you as Secretary-Treasurer. I have enjoyed occupying this position and your confidence in electing me to serve in it since 1990. This has been a rewarding, fulfilling, and challenging endeavor which I have come to totally enjoy. I relinquish this job with misgivings, but with sincere gratitude to the House of Delegates for this opportunity to serve.

William P. VonderHaar, MD
Secretary-Treasurer

Report of the Editor

The *Journal of the Kentucky Medical Association* has provided great service and benefit to physicians and health care providers in Kentucky since 1903. As the page turns to our *second century of publication* and the new millennium, it is my sincere goal that *The Journal* will continue to meet your needs with educational and scientific value; and that it will keep you apprised of the whys and wherefores of the policies and decisions of the Kentucky Medical Association and Board of Trustees concerning vital issues facing our profession, not only in Kentucky, but nationwide.

The *Journal* stands as an antidote to the forces of deprofessionalization, the likes of which would have been unimaginable at the beginning, or even the middle, of the 20th century. We are professionals, and communicating what we see and hear and think and learn will sustain us in that professional mode. The *Journal's* pages are open to all practicing physicians, medical students, residents, others in the medical community, and guest contributors whose satisfaction comes from enhancing and sustaining that professionalism through communication. Our continued success lies in your hands.

In January 1999, we took our highly visible, respected publication and made changes to its design and content. This was an effort to streamline the reading process, enhance visual appeal, allow for easier scanning of articles, and be more informative. We trust that you feel we have achieved our goal.

The editors are champions of medical information, and it is a pleasure to serve with each of them. They give generously of their time for the ongoing success of *The Journal* and remain committed to publishing clinical material that is of high quality and relevance. This group constitutes a broad specialty representation and each one brings a unique quality to the table. They are Daniel W. Varga, MD, Scientific Editor, internal medicine; Stephen Z. Smith, MD, Assistant Scientific Editor & Book Review Author, dermatology; and Assistant Editors Kimberly A. Alumbaugh, MD, obstetrics/gynecology; Carolyn D. Burns, MD, pathology; Daniel P. Garcia, MD, allergy and clinical immunology; Jaroslav P. Stulc, MD, general surgery; and your Editor's area of expertise is gastroenterology/internal medicine.

The Board met 10 times during 1998, and of the 37 manuscripts reviewed (all unsolicited), the editors accepted 25, rejected 4, and returned 8 with recommendations for revision, indicating a 67.6% acceptance rate.

During 1998, *The Journal* featured 16 original scientific articles representing the efforts of 43 authors; 3 Grand Rounds contributions representing 7 authors; and 14 special articles representing 34 authors. These articles presented a rich variety of socioeconomic information on advancing technology, legal issues, ethics, and academic trends. *The Journal* also featured a complete preliminary program for the 1998 Annual Meeting, as well as the entire proceedings of that meeting; Alliance updates;

numerous editorials and letters discussing medical issues of interest to Kentucky physicians; a plethora of pertinent information in the highly successful monthly section headlined "Monitoring Medicine"; and of course, Association coverage.

We should all be heartened by the knowledge that our Association goes to great lengths to be fiscally responsible. *The Journal* continues to face this challenge by prudently controlling costs. *The Journal* Board and staff remain vigilant in their efforts to provide the best publication possible within our budget constraints.

As science, technology, and medical practice evolve and we ponder the challenges certain to be encountered in the 21st century, we recognize that the need for active physician participation in all areas of Association affairs has never been greater. The Editorial Board is interested in your comments, both positive and negative, and encourages you to write us.

It is a privilege to continue steering this enduring and invigorated publication toward the 21st century, and I thank the Board of Trustees for its continued support. Also, I thank you, the readers of our magazine—you inspire me.

A. Evan Overstreet, MD
Editor

Report of the Delegates to AMA

Your AMA delegation consists of five Delegates and five Alternate Delegates, which you elect. The number of delegates allowed from each state depends on the number of AMA members in each state. The delegation meets with the AMA House of Delegates twice a year—at the Annual Meeting each year in June and the Interim Meeting held each year in December.

Each Delegate and Alternate has a continuous assignment to one of nine standing reference committees. Additionally, special reference committees are appointed from time to time by the AMA Speakers. At each meeting the volume of materials considered by the AMA House is voluminous. By maintaining reference committee assignments among the members of the Kentucky delegation, continuity of knowledge of subject matter is maintained.

Although Kentucky is a small state and has a proportionally small number of Delegates, the delegation continues to expand because of representation by Kentucky physicians in other capacities. In addition to the ten Delegates and Alternates, Kentucky also enjoys having a Delegate representing the College of Preventive Medicine, F. Douglas Scutchfield, MD, Lexington; the American Psychiatric Association, Judy M. Linger, MD, Georgetown; and a new resident of Kentucky representing the American Academy of Ophthalmology, Richard Mills, MD. Kentucky, too, enjoys having a member of the AMA Board of Trustees, Bruce A. Scott, MD, Louisville.

Although there were many issues considered by the AMA House of Delegates this year, as always, a few matters received priority attention. In the wake of the Sunbeam matter and some controversy over the evaluation management codes, into which AMA had input, an ad hoc committee on structure and governance was appointed by the AMA House to review the way AMA operates and is managed.

The report of this ad hoc committee consumed a majority of the 1998 Interim Meeting. Some of the recommendations developed by that group were:

- development of a strategic plan for the AMA with input from all components of the house of medicine;
- development of a risk management program;
- solicitation of regular input from all levels of the federation;
- amendment of the AMA Bylaws to preclude the board chairman from running for the presidency; and
- a directive that the AMA be more responsive to member requests.

A number of less prominent actions were undertaken to revise AMA operations, but the organization has been very responsive to these directions, and the AMA is assuming an even greater and more effective advocacy role for physicians.

Another major effort undertaken was evaluation and amendment of the Principles of Medical Ethics. The AMA's Principles of Medical Ethics were first adopted in 1847, and have undergone little substantive change since then. A need has been felt for the Principles to reflect a "new

relevance" commensurate with modern times to incorporate patient-oriented rights and the new ethical climate brought on by managed care.

This is an ongoing effort that will take some time and quite a bit of discussion to conclude. However, this issue, again, is reflective of the AMA's commitment to meet change with change and to try to serve its members better.

The issue of collective bargaining was deeply evaluated throughout the year by the House. In June a series of directions were adopted by the House which have gained considerable notice in the popular media. In summary, the positions adopted by the House on collective bargaining were that:

- All activities must conform to the Principles of Medical Ethics, and physicians should not strike.
- If allowed by the Labor Relations Act, a bargaining unit for residents, fellows, and employed physicians should be instituted. (The definition of employed physicians is very narrow);
- Work for national legislation to allow negotiating units for self-employed physicians and medical groups.
- Work with the Department of Justice and the Federal Trade Commission to help states achieve "State Action Doctrine" legislation.

The majority opinion held that this exploration of collective bargaining was not a commitment to unionism, despite what the popular press has indicated. While media support on any endeavor is ideal, it is hardly expected. A much more critical judgement lies in the hands of patients. One of the factors that resulted in the AMA's actions on collective bargaining was the dissatisfaction by physicians with managed care. There is a parallel and similar dissatisfaction on the part of many patients, so their critical judgment of this AMA move may well not be the same as that of the media.

Complementing collective bargaining efforts has been an intense focus on patient protection activities by the AMA, which can be seen reflected by many major debates and votes underway by Congress on related legislation. Information on KMA's legislative activities appears elsewhere and provides more details on specific endeavors, but managed care changes in patients' rights are a critical adjunct to collective bargaining concerns.

Other major efforts undertaken by the AMA this year which were considered and directed by the House of Delegates were related to evaluation and management code payments and post-payment audits under Medicare, the sixth scope of work of the professional review organizations, the extension of Hospice benefits to 12 months from prognosis, and obviously developing counterpoints to the fraud and abuse efforts of the Health Care Financing Administration.

This will be my last report as the Senior Delegate to AMA. In my many years as a member of this delegation and as its chairman, I have enjoyed the intense review and debate of issues, the comradeship of the members of the House of Delegates and the other delegation members, and the many friendships I have had the pleasure to establish. I cannot provide enough commendations to the other members of the delegation, other than to thank them individually. They are: Wally Montgomery, Bob Goodin, Ardis Hoven, Don Swikert, Bob DeWeese, Greg Cooper, Preston Nunnell, Bill Monnig, and Baretta Casey. These individuals are effective, dedicated physicians and my personal friends, and I cherish the time we have been able to spend together. I would also like to express my deep appreciation to the Board of Trustees and, particularly, to this House of Delegates for the honor of representing you.

Donald C. Barton, MD
Senior Delegate

Report of the Executive Vice President

The primary role of staff is to facilitate implementation of association policies, serve as the organizational memory of KMA and provide continuity to KMA leadership. Much of staff's activities are embodied in committee reports before the House of Delegates, the execution of "Agenda B" directives, and the implementation of the KMA Strategic Plan. Both Agenda B and the Strategic Plan are addenda to the Report of the Chair of the Board of Trustees.

KMA has been fortunate over the years to have excellent physician leadership who step up to the plate every day on behalf of Kentucky physicians. This year was no exception. President Stephens, in his quite unassuming way, personifies the image of the small town family practitioner.

He is open to new ideas, but steadfast in his opinion about what is good and bad medicine and what is best for his patients. He served KMA in many capacities over the years, including Delegate, Trustee, Board Chair, President of the Rural Kentucky Medical Scholarship Fund, and President. Doctor Stephens is a steady, thoughtful, reflective, and fair person. It has been a true pleasure for staff to work with him this year.

Greg Cooper, MD completed a second outstanding term as Chair of the Board of Trustees. He guided the deliberations of the Quick Action Committee, Executive Committee, and Board efficiently, allowing the Board to process a significant amount of business during its two-day sessions. He was always available, did his homework, and presided with humility and humor. As a representative of KMA's younger membership, he brought a new perspective to the role of Board Chair.

President-Elect Carlross has worked behind the scenes preparing for the 2000 Kentucky General Assembly. For over a year, he has built support in the Patton Administration to allocate funds to make childhood vaccines available to all Kentucky children free of charge. His efforts led to assurance from the Governor that the program would receive full and serious consideration in the 2000 budget preparation process. His enthusiastic approach to membership retention and recruitment and commitment to KMA is inspiring, and we look forward to his term as President.

Secretary-Treasurer VonderHaar completes his ninth year in that post. He has always been available to staff, usually on short notice. He is never too busy to take a call, answer a question, address a problem, speak with the press, or testify before a legislative body. He is in the Headquarters Office frequently and has given an unbelievable amount of time during his tenure. His guidance helped maintain KMA's strong financial position as evidenced by the fact that there has been no general dues increase in 13 years. Doctor VonderHaar's commitment to KMA and the profession is exemplary, and staff is truly grateful for his availability, support, and leadership.

Donald C. Barton, MD, leaves the KMA Board this year after serving over 20 years. He has been elected or appointed to practically every job within KMA. He has served medicine at all levels and is widely known and respected in the AMA House of Delegates, where he served as Senior Delegate from Kentucky and Chair of the Southeastern Delegation. He avoids the limelight and says very little. However, when he does speak, people listen and his views usually carry the day. Doctor Barton's lifetime of political activity, and his expertise and guidance through the minefields of Congress and the General Assembly have contributed immeasurably to his profession. He is an icon of Kentucky medicine, and his influence and perspectives will be sorely missed. We wish him well.

As directed by the 1998 House of Delegates, a major priority has been implementation of the KMA Strategic Plan. Details are in the implementation report mentioned above. A survey of the House of Delegates and other stakeholders revealed that KMA's legislative activities were the most important member benefit. Those activities have continued full force throughout this year. KMA continued to participate in the Interim Committee meetings held in Frankfort and in the ongoing regulatory process. We work on a daily basis with the Governor's Administration, officials, and staff. KMA undertook a survey of 250 primary care physicians' attitudes toward alternative and complementary medicine for the Legislative Research Commission and provided testimony before the legislatively appointed Committee on Alternative and Complementary Care. KMA testified before numerous committees on issues related to medical care.

KMA leadership spent two days in Washington, DC, calling on Kentucky's congressional delegation in an effort to encourage support for patient protection legislation supported by AMA and KMA. Meaningful patient protection legislation has become a strongly partisan issue, one that both parties are trying to exploit prior to the 2000 Presidential and congressional elections. Unfortunately, the losers in this political tug-of-war have been patients and their physicians.

In the course of developing the Strategic Plan, the observation was made that a key staff member of KMA's legislative team was nearing retirement. The plan recommended that efforts to assure continuity in KMA's legislative staffing be undertaken. In November of 1998, Marty White was welcomed to the staff to work with Don Chasteen, KMA's senior legislative representative, to become familiar with KMA's political and philosophical approach to the legislative process. This change will provide a three-year "residency" in legislative relations. KMA's legislative consultants, Bill Doll



and John Cooper, who have represented the Association for many years in a very effective and professional manner, bolster these efforts.

The major priority identified in the Strategic Plan was the recruitment and retention of membership. Of the physicians in Kentucky who are eligible for active membership, 71% are members of KMA. The average nationally is 44%. The challenge to any organization is the ability to communicate its value to the member and prospective member in a way that will at least encourage their financial participation and, ideally, personal involvement. A Member-Get-A-Member campaign was carried out between August 1998 and March 1999, which brought in 60 new KMA members and 14 new AMA members. Due to the success of that project, the program will be repeated this year.

To bolster the membership campaign and to bring KMA's message to all areas of the state, an ambitious schedule of educational programming was offered in every part of Kentucky. Programs on Basic and Advanced Coding, Basic and Advanced Managed Care, Stark Law, Practice Audits, Risk Management (presented in cooperation with KMIC), and Corporate Compliance were presented in 31 separate offerings and were attended by more than 500 physicians and office staff. While both members and nonmembers attended these programs, nonmembers paid a higher registration fee. Additional programs will be offered in the fall. Because many people participated in these educational events, KMA used the opportunity to give attendees an overview of Association activities. A short video "commercial" was shown at the seminars and, hopefully, gave participants a better idea of the many activities KMA provides on behalf of physicians and their patients. In addition, members of the Board of Trustees visited and spoke before 25 hospital medical staff meetings this year. The Board's goal is to visit with every hospital medical staff to bring KMA's message to physicians.

KMA's in-house Legal Counsel continuously produces up-to-date legal and regulatory information for the membership, which is disseminated through the KMA web site, *Journal* and *Communicator*. The legal staff produced the *KMA Legal Handbook*, which was provided to every KMA member as a free member benefit. The seminars on Corporate Compliance and Fraud and Abuse were developed in-house and presented in an effort to provide the very latest information on that subject at the lowest possible cost to attendees.

This is only a very brief description of a small part of the implementation of the Strategic Plan. While a significant part of the plan has been realized, other recommendations will be implemented throughout this year, and in years to come.

According to the July 14 edition of *USA Today*, more than 22 million US adults went online to find health information last year. Technology and the Internet are revolutionizing the way people do things today. Technology keeps changing faster than most of us can keep up with, but it also allows greater productivity and the ability to disseminate information quickly. KMA's web site undergoes continuous development and, hopefully, improvement. KMA plans to enhance its ability to produce e-mail to large segments of the membership, make legislative information immediately available and bring KMA's policies both on-line as well as through the traditional hard copy. KMA is serving as a test site for the AMA to formulate our policies into an electronic format with a word search capability. Once completed, that information will be accessible via both the KMA and AMA web sites. The AMA plans to eventually post all state association policies on line in a similar format.

Technology has provided KMA staff the capability to provide increased numbers of services at enhanced levels with fewer employees than we had five years ago. Automation allows us to produce a greater volume of information in less time and at less expense. As an example, KMA's in-house print shop offers economies of scale and immediate production of printed information. During the week of the KMA Annual Meeting alone, 164,000 sheets of paper will be printed, and over two million sheets were printed over the last calendar year. That includes everything from letterheads to the *Communicator*, *Legislative Handbook*, and seminar materials. Aside from the *Journal*, the vast majority of KMA's printing is done in-house.

I want to take this opportunity to recognize and thank the KMA staff, for their commitment, loyalty, dedication, and great attitude. They are special people and their work ethic is unmatched. They know what they are doing, and they do it well. They work long hours, work hard, and work

smart. In addition to their knowledge and determination, our staff brings over 240 years of KMA experience to their assignments.

Albert Einstein was quoted as saying, "The significant problems we face today cannot be solved at the same level of thinking we were at when we created them." As we contemplate the end of a year, a decade, a century and a millennium, those words were never more meaningful.

Thank you for the opportunity to serve and for your individual contributions. We look forward to another productive year.

William T. Applegate
Executive Vice President

END OF CONSENT CALENDAR ITEMS

Physician Advisory Committee to Health Kentucky (Health Care Access Foundation)

The Physician Advisory Committee to Health Kentucky has overall responsibility for monitoring and guiding the referral system to the Health Care Access Foundation Program. Members of the operational committee also serve as a medical advisory group on questions that may arise during the course of the program's operations.

The Kentucky Physicians Care Program, which is the physician element of Health Kentucky, provides access to nonemergency health care to uninsured Kentuckians with incomes at or below 100% of the federal poverty level at no cost to the patient.

Originally, the Kentucky Physicians Care Program offered only physician and hospital services. Now, at no cost, pharmaceutical products, dental care, hospice, and home health care services are also available. This year over 2,000 Kentucky physicians are participating in the program.

In addition to physician participation, there are approximately 120 hospitals, 143 participating dentists and 502 participating pharmacies. An unknown quantity of free home health care and hospice services have also been provided through this program. The biggest increase in utilization has come in pharmaceutical services as additional companies and products are being added.

In an effort to expand physician participation, targeted letters were sent to physicians in several KMA trustee districts and the committee appreciates the effort given to increase participation levels. Health Kentucky also developed a first-class video to further assist in the recruitment of physicians to participate in the program.

As in the past, the committee continues to believe that the program is worthwhile and serves a useful purpose providing a conduit for individuals to primary physician services. For that reason, the committee recommends:

1. KMA continue its endorsement of the Health Kentucky goal of increasing access to care for Kentucky's less fortunate citizens.
2. KMA encourage all Kentucky physicians to continue to voluntarily participate in Kentucky Physicians Care to the extent possible.
3. KMA continue its endorsement of Health Kentucky contingent on:
 - a) Program funding being continued, as appropriate, by Health Kentucky.
 - b) A continuing commitment from the Cabinet for Human Resources to evaluate the program applicants for eligibility as is currently done.
 - c) The other participating provider groups maintaining the same or increased level of participation in the foundation program.
 - d) Health Kentucky making documented efforts to vigorously encourage the participation of all other health care delivery and/or financing organizations in the foundation's program, as may be appropriate.
 - e) Health Kentucky making documented efforts to make Kentucky legislators and the general public aware of the plight of those ineligible for Medicaid assistance, solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

I appreciate the continued interest and participation of the members of the Advisory Committee and am most grateful for the generosity of the physicians in this state who continue to give so freely of their services.

Donald C. Barton, MD
Chair

RECOMMENDATIONS:

1. KMA continue its endorsement of the Health Kentucky goal of increasing access to care for Kentucky's less fortunate citizens.
2. KMA encourage all Kentucky physicians to continue to voluntarily participate in Kentucky Physicians Care to the extent possible.
3. KMA continue its endorsement of Health Kentucky contingent on:
 - a) Program funding being continued, as appropriate, by Health Kentucky.
 - b) A continuing commitment from the Cabinet for Human Resources to evaluate the program applicants for eligibility as is currently done.
 - c) The other participating provider groups maintaining the same or increased level of participation in the foundation program.
 - d) Health Kentucky making documented efforts to vigorously encourage the participation of all other health care delivery and/or financing organizations in the foundation's program, as may be appropriate.
 - e) Health Kentucky making documented efforts to make Kentucky legislators and the general public aware of the plight of those ineligible for Medicaid assistance, solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

RECOMMENDATIONS, REFERENCE COMMITTEE A:

Reference Committee A reviewed Report 10 and its Recommendations pertaining to participants in Kentucky Physicians Care. Reference Committee A recommends the report and its Recommendations be adopted.

RESOLUTION 99-102**Section Name Change
Board of Trustees**

WHEREAS, the American Medical Association Resident Physicians Section recently changed its name to the AMA Resident and Fellows Section; and

WHEREAS, this more adequately represents the composition of membership eligible for the section; and

WHEREAS, the KMA Resident Physicians Section (KMA-RPS) wants to be in concert with its national organization; now, therefore, be it

RESOLVED, that the name of the KMA Resident Physicians Section be officially changed to the KMA Resident and Fellows Section; and be it further

RESOLVED, that Chapter 1, Section 2 (c) of the KMA Bylaws be amended as follows:

~~"Resident Physicians Section~~ **Resident and Fellows Section.** Doctors of medicine or osteopathy . . . who are serving in AMA approved training programs in Kentucky shall be eligible for membership in the ~~Resident Physicians Section~~ **Resident and Fellows Section** of the Kentucky Medical Association. The ~~Resident Physicians Section~~ **Resident and Fellows Section** shall be governed by its own Constitution and Bylaws . . . The ~~Resident Physicians Section~~ **Resident and Fellows Section** will be represented in the KMA House of Delegates by one voting representative elected by the Governing Council of the ~~Resident Physicians Section~~ **Resident and Fellows Section."**

RECOMMENDATIONS, REFERENCE COMMITTEE A:

Reference Committee A reviewed Report 102, Section Name Change, submitted by the Board of Trustees. The Resolution proposes a change in the name of that section to the "KMA Resident and Fellows Section" as well as a change in Chapter 1, Section 2, of the KMA Bylaws reflecting that same change. Testimony was heard supporting this effort to bring the name of this KMA Section in concert with the corresponding section of the American Medical Association.

Reference Committee A recommends that Resolution 102 be adopted.

RESOLUTION 99-107**Dues Delinquency Date
KMA Board of Trustees**

WHEREAS, the American Medical Association House of Delegates

has adopted policy to change the AMA dues delinquency date from April 30 to March 1, effective in the year 2001; and

WHEREAS, the KMA dues delinquency date is currently set in the KMA Bylaws as April 1; and

WHEREAS, the KMA, in cooperation with its component medical societies, has always worked in support of federation efforts to enhance membership; and

WHEREAS, the better coordination of membership dues processing improves overall service to members and eliminates confusion associated with redundant billing; now, therefore, be it

RESOLVED, that the delinquency date for KMA dues be changed to March 1, effective in the year 2001; and be it further

RESOLVED, that Chapter 1, Section 2 (g) of the KMA Bylaws be amended to read as follows:

. . . If a member in good standing enters service prior to ~~April~~ March 1 and has paid his dues for that year, he shall receive all publications and other benefits applicable to his class of membership in the Association and shall owe no further dues until January 1 following his release. If a member in good standing enters service prior to ~~April~~ March 1 without paying his dues for that year, he shall receive publications and other benefits but shall owe the dues applicable to his class of membership immediately following his release from active duty. Members whose dues have not been received by ~~April~~ March 1 are not in good standing.

and be it further

RESOLVED, that Chapter IX, Section 2 of The KMA Bylaws be amended to read as follows:

. . . or make the report as required, on or before the first day of ~~April~~ March in each year. . .

RECOMMENDATIONS, REFERENCE COMMITTEE A:

Reference Committee A next reviewed Resolution 107, Dues Delinquency Date submitted by the KMA Board of Trustees, which proposes a change in the delinquency date for KMA dues from April 30 to March 1, beginning in the year 2001, and an associated modification in the KMA Bylaws to reflect that change. Testimony was heard regarding this effort to bring the KMA dues delinquency date into concordance with the AMA dues delinquency date.

Reference Committee A recommends that Resolution 107 be adopted.

RESOLUTION 99-117**Relief for Physicians from Administrative Burdens
Jefferson County Medical Society**

WHEREAS, time is a physician's most valuable asset; and

WHEREAS, governments, third parties and employers are requesting more and more forms and other time-consuming reports and activities from physicians without compensating for the time required for compliance; and

WHEREAS, such paperwork requirements frequently result in delayed payment, denied payment or harassment of the patient or physician if the required forms and reports are not filled out "correctly"; now, therefore, be it

RESOLVED, that the Kentucky Medical Association establish a committee or utilize an existing committee to study the problem of increased paperwork burdens and their impact on patient care; and be it further

RESOLVED, that this committee be directed to develop recommendations for alleviating the problem and to report these recommendations to the Board of Trustees or House of Delegates for appropriate action.

RECOMMENDATIONS, REFERENCE COMMITTEE A:

Reference Committee A next reviewed Resolution 117, Relief for Physicians from Administrative Burdens, submitted by the Jefferson County Medical Society. Resolution 117 calls for the establishment of a committee, or utilization of an existing committee, of the KMA to study the relationship of increased paperwork burdens on patient care and to make recommendations for alleviating this problem. Testimony was heard from the author of this resolution, Harold Haller, MD, explaining the general spirit of this resolution. Additional testimony was also heard suggesting that such a committee could address credentialing or referral process issues.

Reference Committee A recommends that Resolution 117 be adopted.



RESOLUTION 99-120

Policy Sunset Provision Board of Trustees

WHEREAS, policies of the House of Delegates should be periodically reviewed, retained, revised, or deleted; now, therefore, be it

RESOLVED, that a sunset mechanism with a ten-year time horizon shall exist for all KMA policy positions established by the House of Delegates; and be it further

RESOLVED, that under this sunset mechanism, a policy will cease to be KMA policy after ten years and the House will be informed annually of those policies being "sunsetting," unless action is taken by the House of Delegates to reestablish them; and be it further

RESOLVED, that any action of the House of Delegates that reaffirms or modifies an existing policy position shall reset the sunset "clock," making the reaffirmed policy viable for ten years from the date of its reaffirmation unless subsequent House of Delegates action amends, deletes or alters existing policy; and be it further

RESOLVED, that the Speakers of the House shall appoint a committee to review all policy ten years old and older, develop initial recommendations for the disposition of each policy item, and report these efforts for action by the House at the 2000 annual session.

RECOMMENDATIONS, REFERENCE COMMITTEE A:

Reference Committee A next reviewed Resolution 120, Policy Sunset Provision, submitted by the KMA Board of Trustees, which establishes a termination mechanism whereby KMA policy would lapse after 10 years if not reaffirmed by the House of Delegates. Testimony was heard from the Board of Trustees regarding the rationale for this policy and the availability of help from the AMA in attempts to computerize the KMA Policy Compendium.

Reference Committee A recommends that Resolution 120 be adopted.

RESOLUTION 99-121

Physician Prescribed and Administered Drugs McCracken County Medical Society

WHEREAS, in the interest of patient care and efforts to reduce medical costs, the Kentucky General Assembly excluded most facets of medical care including patient medical goods and supplies, professional services, hospital bills and other components from the Kentucky sales tax; and

WHEREAS, prescription medicines dispensed by a registered pharmacist are specifically excluded from the Kentucky sales tax; and

WHEREAS, the Kentucky Revenue Cabinet adopted a regulation years ago, since lapsed, that required physicians to pay sales tax on drugs and biological agents which the physician or staff directly administered or dispensed to the patient; and

WHEREAS, the Revenue Cabinet has begun auditing physician offices throughout Kentucky and assessing backpayment, plus interest and penalty, on sales taxes for drugs administered to patients over a period of years; now, therefore, be it

RESOLVED, that KMA supports an amendment to regulations or statutes stating that drugs directly administered or dispensed by physicians or their staffs to patients should be exempted from the sales tax in the exact manner as "pharmacist prescribed" medications; and be it further

RESOLVED, that the KMA work with the Administration and the Revenue Cabinet to adopt regulations excluding from Kentucky sales tax drugs administered by treating physicians or their staffs to their patients; and be it further

RESOLVED, that in the event regulations are not submitted by the Revenue Cabinet, that KMA seek legislation that amends existing statutes to provide exemption from sales tax for drugs administered by physicians or their staffs.

RECOMMENDATIONS, REFERENCE COMMITTEE A:

Reference Committee A next reviewed Resolution 121, Physician Prescribed and Administered Drugs, submitted by the McCracken County Medical Society. This resolution recommends that the KMA support an amendment to state regulations or statutes directing that drugs administered and dispensed by physicians or their staffs be exempted from sales tax just as are "pharmacist prescribed" medications. Testimony was heard

explaining the current potential liability of physicians for sales tax on drugs administered or dispensed to their patients.

Reference Committee A recommends that Resolution 121 be adopted.

Action on the floor of the House revised Resolution 121 by replacing "prescribed" with "dispensed" in the last line of the 1st Resolved. Resolution 121 was adopted as amended on the floor of the House.

Mr Speaker, Reference Committee A recommends the adoption of this report as a whole, as amended.

Mr Speaker, I want to personally thank the other members of Reference Committee A for their assistance to the House of Delegates in formulating policies on some very worthwhile issues. Members of the committee were: John W. Collins, MD, Lexington; Charles G. Nichols, MD, Pikeville; LaDonya Reed, Lexington; K. Thomas Reichard, MD, Louisville; and Terry Tyler, MD, Owensboro. I also wish to thank Ms Teresa Harper for her help and guidance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE A
Theodore H. Miller, MD Edgewood, Chair
John W. Collins, MD, Lexington
Charles G. Nichols, MD, Pikeville
LaDonya Reed, Lexington (MSS)
K. Thomas Reichard, MD, Louisville
Terry Tyler, MD, Owensboro

Editorial Note: Unless otherwise indicated, the reference committee recommendation on each report and resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE B

Ronald E. Waldrige, MD, Shelbyville, Chair

11. Report of the Scientific Program Committee
 12. Report of the Scientific Exhibits Committee
 13. Report of the Continuing Medical Education Committee
 14. Report of the Council for Continuing Medical Education
 15. Report of the Cancer Committee
 16. Report of the Physician Workforce Committee
 17. Report of the Organized Medical Staff Section
 18. Report of the Rural Kentucky Medical Scholarship Fund
- Resolution 101 — UL Off Campus Teaching Center at Trover Foundation (Hopkins County Medical Society)
- Resolution 104 — Mandatory Hospitalist Programs (Board of Trustees)
- Resolution 126 — Pap Smears (Fayette County Medical Society)
- Resolution 127 — Colorectal Cancer Screening (Fayette County Medical Society)
- Resolution 129 — Cancer Screening (Board of Trustees)
- Resolution 130 — Kentucky Breast Cancer Task Force (Board of Trustees)
- Resolution 134 — Cervical and Colorectal Cancer Screening (Board of Trustees)

ITEMS FOR CONSENT

Reference Committee B reviewed the following items and recommends they be filed, by consent of the House, without discussion:

11. Report of the Scientific Program Committee — filed
12. Report of the Scientific Exhibits Committee — filed
13. Report of the Continuing Medical Education Committee — filed
14. Report of the Council for Continuing Medical Education — filed
16. Report of the Physician Workforce Committee — filed
17. Report of the Organized Medical Staff Section — filed
18. Report of the Rural Kentucky Medical Scholarship Fund — filed

Mr Speaker, Reference Committee B recommends adoption of the Consent Calendar as a whole.

Scientific Program Committee

The Scientific Program Committee selected "Health Care Alternatives" as the overall theme for the 1999 KMA Annual Meeting Scientific Program. Each morning session will focus on the theme from the perspective of the various specialties participating in the meeting. The committee members and representatives from the 21 specialty societies have worked hard to bring some of the country's outstanding speakers to the meeting, and it is hoped that the membership will find their presentations interesting and useful.

The Scientific Program was planned last fall and a meeting was held in December with the presidents and/or representatives of the 21 specialty groups that will participate in the annual session. Specialty groups' scientific programs held in conjunction with the morning general sessions have proven invaluable, and provide an excellent source for the continuing medical education of the membership. I personally appreciate the excellent cooperation the committee has had from all of the specialty societies in planning the overall meeting, and I thank them for their suggestions and assistance, and encourage them to continue to assist the committee in finding new and innovative ideas for topic selection and presentation.

The 1998 Annual Meeting was held at the Hyatt Regency Hotel/Commonwealth Convention Center in Louisville, Kentucky, with an attendance of 2,042.

Exhibitors were asked to fill out evaluation forms on Tuesday and Wednesday during the 1998 meeting. This allowed a better assessment of exhibitors' viewpoints and provided new ideas for improving the meeting. The exhibitors' comments were, overall, positive.

Results from physicians' evaluation forms from the general sessions and specialty group meetings were again positive and revealed that physicians attended the 1998 Annual Meeting program because of the availability of Category 1 CME credit and the overall program content.

The 1999 KMA Annual Meeting will be held at the Hyatt Regency Hotel/Lexington Center in Lexington. Meetings of the KMA Board of Trustees, House of Delegates, reference committees, KEMPAC, and Alliance, as well as various food functions, will be held in the Hyatt Regency Hotel. General registration, specialty group meetings, general sessions, and the technical exhibit hall, as well as scientific and education exhibits, will be located in Lexington Center. We urge members and their staffs to visit the exhibits. These informal contacts offer numerous opportunities, education reviews, and discussion of new products and familiarization with new equipment, free from the interruptions or distractions of the office or hospital.

At this year's Annual Meeting, the General Sessions will again be held on Tuesday and Wednesday mornings, and specialty groups will meet on Tuesday and Wednesday afternoons.

The Kentucky Medical Group Management Association (KMGMA) will meet in conjunction with the 1999 Annual Meeting, and the Kentucky Medical Insurance Company will again sponsor a Risk Management Workshop for Office Assistants, as well as a separate workshop for physicians.

The scientific sessions are again designated for AMA PRA Category 1 continuing medical education credit and are also approved for prescribed credit by the American Academy of Family Physicians.

As always, I am very grateful for the efforts of those who have assisted in the formation of the program, particularly the Program Committee, specialty group presidents, and program chairs. The Scientific Program Committee always welcomes suggestions for future programs.

James L. Borders, MD
Chair

Scientific Exhibits Committee

Although the Scientific Exhibits Committee does not meet formally, the work that is put into the scientific exhibits area continues to be a strong component of the overall success of the Annual Scientific Meeting. The activities of the committee are carried out by mail and telephone. We notify members through the *Journal of the Kentucky Medical Association* and the *KMA Communicator* of the availability of space and provide applications to interested individuals. In 1998, six outstanding scientific exhibits were approved by the Scientific Exhibits Committee. We also provide exhibit space for entities such as the Commission for Children with Special Health Care Needs and the Attorney General's Prescription Drug Abuse Task Force. We wish to express our appreciation to the following exhibitors at

the 1998 Annual Meeting:

- **Quality Improvement & Management in a Dermatologic Surgery Office**
W. Patrick Davey, MD
- **Kentucky Cancer Program**
University of Louisville
- **School Screening of Scoliosis in Kentucky**
John J. Vaughan, MD; Marion Bruestle, RN; G. Chris Stephens, MD; Thomas E. Menke, MD; and Flo White, MA
- **Meningiomas of Brain and Spine: Management**
John J. Guarnaschelli, MD; David A. Petruska, MD; Wayne G. Villanueva, MD; and S. Stawicki
- **Minimally Invasive Cardiac Surgery**
Sibu P. Saha, MD; Anthony G. Rogers, MD; Gary F. Earle, MD; Craig A. Nachbauer, MD; Bassam A. Khalil, MD; and Robert O. Mitchell, MD
- **What is the Best and Most Cost-Efficient Test for Evaluation of Low Back and Neurogenic Leg Pain by Primary Care Physicians?**
John J. Vaughan, MD; Marion Bruestle, RN; G. Chris Stephens, MD; Thomas E. Menke, MD; and Flo White, MA

I want to take this opportunity to thank the members of the committee for their dedication in serving on the Scientific Exhibits Committee. The scientific exhibits area continues to be a significant and substantial forum for the exchange of necessary and practical scientific information at the Annual Scientific Meeting, and we feel that it is worth all physicians' time to stop at the scientific exhibits area during the Annual Meeting and visit with the scientific exhibitors.

Richard A. Kielar, MD
Chair

Continuing Medical Education Committee

The Continuing Medical Education Committee continues to oversee the accreditation of organizations providing CME for physicians in Kentucky. The committee met on three occasions this year.

The current accreditation process consists of the committee assisting organizations in developing a working education program and then monitoring organizations' programs through formal surveys. Currently, KMA accredits 31 hospitals, AHECS, medical societies, and large groups in Kentucky so they can in turn conduct their individual CME activities.

Summary data from the 1998 CME Annual Report was quite impressive, as more than 1,000 CME activities were reported by KMA-accredited providers. Over 3,000 hours of Category 1 CME were provided, with more than 26,000 physicians and 15,000 other health professionals attending these programs. The survey of providers also revealed that Kentucky physicians donated almost 3,000 hours of volunteer service last year either serving on a local CME committee or presenting at CME activities.

During the past year, the CME Committee conducted two initial surveys for new applicants. One applicant, Jennie Stuart Medical Center, Hopkinsville, was granted a one-year provisional accreditation. The second applicant was not granted accreditation but is working toward reapplication after an education process. Surveys were also conducted for 11 institutions applying for reaccreditation. Five institutions up for reaccreditation were granted an accreditation period of four years based on ability to meet the criteria of the KMA Essentials and Standards, which all organizations must demonstrate to become accredited. Four organizations were given a three-year accreditation period, one institution received a two-year accreditation period, and one organization's accreditation was withdrawn.

The committee also reviewed the annual reports from each accredited provider. In addition to the data summarized above, the report covered how the providers addressed concerns noted in their last site surveys and how they were complying with the Standards for Commercial Support and joint sponsorship required for accreditation.

The restructuring of the Accreditation Council on Continuing Medical Education accreditation process has been a major topic for the past few years. The ACCME is the national body that not only accredits state medical societies and other organizations to provide CME, but also empowers and recognizes state medical societies to accredit hospitals and other health care organizations within their state to provide CME activities.

The committee continues to provide input at the national level regarding these changes. Robert R. Goodin, MD, who serves on the Executive



Committee of the ACCME as well as being a member of the AMA Council on Medical Education, reported that the new system is a result of six years of planning and will be fully implemented by July 2000. State associations and others recognized by the ACCME as accreditors must meet ACCME's guidelines in managing their own CME accreditation system. The committee is currently in the process of reviewing and adopting a new state accreditation system. It is anticipated that the new state system will be presented to our providers at a late fall CME Accreditation Seminar.

CME Committee Chair, Thomas K. Slabaugh, MD, attended the ACCME/State Medical Society Conference in September 1998 and KMA CME staff attended a similar workshop in March 1999. Information was received on the new accreditation system, including a number of tools to use in the process, eg, site survey reporting forms, initial applications, and reaccreditation self-study forms. Other discussion noted at the national meetings included a change in eligibility guidelines for national vs state accreditation. With the exception of medical schools, providers would be accredited through the state if no more than 30% of attendees come from outside the home state or contiguous states. This would eliminate the restriction on state-accredited providers of sponsoring only one national meeting a year.

The committee continues to oversee the nomination and selection process for the KMA Educational Achievement Award. Four nominations were received and considered by the committee in 1998. The recipient of the Educational Achievement Award, which was presented at the 1998 KMA Annual Meeting, was Gordon Hyde, MD, Professor Emeritus of Surgery, University of Kentucky College of Medicine.

The committee has an additional meeting scheduled for September and anticipates an extremely busy year as we work to adopt a new accreditation system and educate physicians, CME providers, and committee members through seminars, newsletters, and surveyor training.

I would like to express appreciation to the committee members for the many hours they contribute to advancing the quality of continuing medical education in Kentucky.

Thomas K. Slabaugh, MD
Chair

Council on Continuing Medical Education

The Council on Continuing Medical Education convened for three regular meetings this year.

The Kentucky Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide CME for its educational offerings and the council's purpose is to oversee this process, assuring compliance with the Essentials and Standards of the ACCME. KMA's current accreditation expires in 1999 and an application for reaccreditation was submitted in April. After a formal resurvey in early June, KMA was awarded full accreditation for four years. Substantial compliance was noted in all the Essentials and Standards.

The ACCME accreditation system is undergoing substantial changes and the council is being educated on the new system that will be fully implemented in July 2000. With the dedicated group of physicians on the council, it is expected that KMA's CME program will readily adapt to the new national accreditation system.

The council works closely with the Scientific Program Committee in planning the Annual Scientific Program to ensure that quality education is offered for Category 1 CME credit. The council reviewed the theme "Health Care Alternatives" and the draft of the program for the 1999 KMA Annual Meeting, including speakers, topics, and learning objectives. The council discussed the summary of evaluation forms from the 1998 meeting, and monitored changes which the Scientific Program Committee made based on attendees' comments.

The 1999 Physician Needs Assessment Survey was conducted in January to determine if KMA's CME program was meeting physician needs in Kentucky. A 9% return from active members revealed that 70% attend KMA's Annual Meeting for CME hours and specialty society meetings and 60% felt the scientific program was effective in meeting education needs. It was interesting to note that the number one topic of interest was alternative medicine.

In addition to the survey, comments from evaluation forms, input

from KMA committees and specialty societies, and action steps from the KMA 1998 Strategic Plan have identified CME needs which have become a part of the overall focus for future CME planning. Some of the programs which the council has approved for 1999 include seminars on "Corporate Compliance for Physicians' Offices," "Risk Management," "Stark Law," and "Driving the Elderly: Issues and Answers for the Aging Driver."

In addition, KMA continues to joint sponsor programs with non-accredited entities. The council approved a need from the Kentucky Society of Anesthesiologists to jointly sponsor its spring meeting in March for 11 hours of Category 1 CME. Almost 50 physicians attended the two-day meeting and the evaluations showed that the speakers and subject matter were well received.

The council also jointly sponsored the spring meeting of the Kentucky Academy of Eye Physicians and Surgeons held June 18-19 in Bowling Green for 7 hours of Category 1 credit. Over 50 attendees rated a majority of the speakers as excellent and gave high evaluations to the program content.

Finally, the council approved the needs and objectives for joint sponsorship with the Kentucky Department for Public Health of the 42nd Annual Maternal and Child Health Conference to be held September 8-10 in Louisville. The three-day session is a multi-disciplinary program focusing on "Risk Assessment and Intervention in Kentucky." This program, which carries up to 12 hours of Category 1 CME, represents the first CME collaboration between KMA and the Department for Public Health.

Last year, the council designated 3 hours of Category 1 CME for a videotape of the Domestic Violence Seminar held September 18, 1997, as an enduring material. All the requirements for enduring materials were met, including identification of target audience, needs assessment, specific learning objectives, educational content, qualified faculty, evaluation, and certification. To date, more than 1,300 physicians have used the videotape to fulfill their Kentucky Board of Medical Licensure requirement for a domestic violence course.

A second enduring material was also approved by the council in late 1998 in joint sponsorship with the Kentucky Cancer Program. *Providers Practice Prevention*, a self-study video program, provided 2 hours of Category 1 CME and was targeted to primary care physicians committed to increasing and improving breast and cervical cancer screening. More than 150 physicians completed the self-study requirements for CME certification.

Overall, activity for the council increased substantially during the past year, with the number of CME offerings sponsored by KMA up 35% over 1997 programs. In 1998, KMA sponsored 72 hours of Category 1 CME for 2,078 attendees. During the first six months of 1999, there have been 17 individual programs either directly or jointly sponsored by KMA, offering 61 Category 1 credit hours. More than 300 physicians and other health professionals attended one or more of these programs.

I would like to thank the members of the council who have served diligently this year evaluating a wide variety of programs and materials for compliance with the Essentials and Standards of CME. In addition, many have also served as site surveyors for the accreditation program under the auspices of the CME Committee. While it is not the responsibility of the council members to do so, many of them took time out of their busy schedules to lend their expertise in surveying hospitals and other organizations in order to improve their physician education programs.

During the coming year, the council will continue to monitor the work of the ACCME and look to make adjustments accordingly to our own system of providing CME. The council would like to thank the Board of Trustees for permission to serve, and looks forward once more to expanded activity in the coming year.

James L. Borders, MD
Chair

Physician Workforce Committee

The Physician Workforce Committee was established to study and recommend policy on current and long-term needs for the physician workforce in Kentucky. The committee met once this year to review a number of workforce issues being addressed at the national level and to discuss local implications for state medical and osteopathic schools and residency programs.

It was reported that over the past 20 years, the number of allopathic

medical schools decreased from a high of 127 to 125 and the number of graduates remained at about 16,000 per year. The number of osteopathic medical schools increased in the same time period from 14 to 19 and the number of graduates increased from 1,151 to about 2,100 per year. Of the IMGs starting residency each year, 59% are US citizens, naturalized citizens or children of IMGs who go to school in other, often their own, countries. IMGs have battled for and now have a section at the AMA.

Reducing the number of entry-level residency positions to 110% of the number of US medical school graduates, as has been proposed by the federal Council on Graduate Medical Education (COGME) and others, would result in a loss of over 6,000 positions. A gradual reduction to 120% of US medical school graduates would be a more balanced approach and allow space for graduates of US medical schools, for US citizen and permanent resident IMGs, and for re-entry of individuals with previous residency training. A 120% decrease would mean a reduction of about 4,300 entry level positions from current levels. AMA policy states that, in the event of reductions in GME positions, access should be maintained for US medical school graduates and for IMGs already legally present in the US.

Funding issues were also discussed by the committee, noting that Medicare is the largest payer to cover the direct costs of GME. Federal and state governments, as well as the VA and military, also contribute to GME through Medicaid. The Council on Medical Education advocates a system which could create a Graduate Medical Education Trust Fund to support the direct costs of GME, housed elsewhere than in the Health Care Financing Administration. The private/public sector advisory body should, in addition to making recommendations about the number and distribution of GME positions, develop a mechanism to distribute funds from the GME Trust Fund. Currently, there is federal legislation in the House and Senate concerning the all payer pool.

An all payer system requires a more explicit determination of GME costs. An accurate assessment of the total costs of maintaining a residency program would be necessary to determine the size of the all payer pool. The budgeting system should be based on a "per resident" amount and should take into account regional cost differences.

The indirect medical education adjustment (IMEA) supports other general costs in teaching institutions, such as the need for more costly staffing and the inefficiencies associated with the presence of a teaching program. The IMEA formula includes the resident-to-bed ratio. A reduction in the number of residents would affect teaching hospitals in two ways: (1) the loss of service making teaching hospitals hire other service providers to replace residents lost through program downsizing and (2) loss of revenue from direct and indirect Medicare adjustments tied to the number of residents. The New York State Demonstration Project should be studied and the results used to develop regulations.

The committee discussed the financial crisis developing in the teaching hospitals due to the Medicare cuts in the Balanced Budget Act of 1997. It was reported that the University of Pennsylvania lost \$90 million last year and UCSF Stanford lost \$50 million. Major losses were also felt by both Kentucky medical schools.

The AMA Council on Medical Education has made recommendations to:

- Reduce the number of federally funded entry-level graduate medical education positions, over time, to no more than 120% of the number of 1997 graduates of US MD- and DO-granting medical schools with monitoring and flexibility in the number and allocation of positions, so that regional and specialty needs can be met.
- Consider the contributions to patient care made by other health professionals in GME planning.
- Appoint an independent advisory body to develop guidelines for the number of funded positions. The advisory body should have significant representation from the medical profession and the academic medical community.
- Provide explicit immunity from antitrust constraints to private professional groups, to allow participation in the national debate on the physician workforce.
- Consider program quality, based on an assessment of educational program outcomes under the leadership of the Accreditation Council for Graduate Medical Education and its Residency Review Committees, in the allocation of funded residency positions.

- Allow no discrimination between US medical school graduates and US citizen/permanent resident IMGs in the allocation of funded residency positions.
- Recommend no increase in the number of graduates from US MD- and DO-granting medical schools over 1997 levels.
- Establish a Graduate Medical Education Trust Fund with contributions from all payers to support the direct costs of GME.
- Maintain a stable funding source with a budget not subject to an annual appropriations process. If a GME Trust Fund is not established, funding for direct costs of graduate medical education should remain within the Medicare program.
- Base budgeting for direct costs on a per resident amount taking into account regional cost differences.
- Have funding follow residents to all educational sites. Any authorization or "voucher" system should permit such distribution of funds to the sites that incur the costs of training.
- Maintain the indirect medical education adjustment (IMEA) through Medicare until explicit alternative mechanisms are in place to support the costs associated with higher acuity in teaching institutions and indirect costs associated with the presence of a teaching program. There should be no reductions in the IMEA beyond that mandated in the 1997 Balanced Budget Act.
- Provide transitional funds to teaching institutions that lose residents as a result of cuts in the number of funded positions.

Another area of interest to the committee is the development of international medical branch campuses. It was reported that Ross University School of Medicine, Dominica, is putting a branch campus in Casper, Wyoming, which would serve about 1,000 students. Wyoming Medical Society and the AMA have strongly opposed this. However, the US Department of Education has deemed the accreditation process used by Dominica to be equivalent to the process used by the Liaison Committee on Medical Education (LCME). AMA will continue to monitor the status of the branch campus and work with county and state medical societies to provide information to legislative bodies and potential students. Plans to establish a branch campus of Kigezi International School of Medicine in Washington have been suspended.

The committee also reviewed recent policy adopted by the Federation of State Medical Boards to encourage state medical boards to license residents and monitor students. Objection has been raised on proposals calling for:

- Students to complete the first two steps of the US Medical Licensing Examination before entering a residency program.
- Residents to complete three years of postgraduate training program before becoming eligible to apply for full licensure.
- Residents to apply to medical boards for a state permit and program directors to report annually on resident disciplinary actions and other problems that could impair residents' ability to serve.
- Medical Boards to require criminal background checks on all residents seeking permits.
- Medical Schools to be encouraged to share disciplinary information on students with medical boards.

It was noted that Danny Clark, MD, President, Kentucky Board of Medical Licensure, aggressively opposed the FSMB policy change at its annual meeting. The committee commends Dr Clark's efforts in this regard, noting that the AMA, AAMC, and AOA all opposed the FSMB's policy.

The Physician Workforce Committee will continue to address and inform the membership on issues at the state and national levels that affect the workforce of physicians in Kentucky. I would like to thank the Board for being permitted to serve and look forward to expanded activity in the coming year.

Robert R. Goodin, MD
Chair

Organized Medical Staff Section

The Organized Medical Staff Section (OMSS) works to assure practicing physicians leadership in the governance of hospitals, other health facilities, and emerging delivery systems through a self-governing medical staff. In this context, the OMSS continues to monitor relevant issues and stands



ready to serve as a communication channel to members.

This year the OMSS continued its strong representation with the American Medical Association OMSS through attendance at the Annual and Interim Meetings. KMA-OMSS Steering Committee members represented Kentucky's interests in a variety of discussions, which included issues relating to mandatory use of hospitalists, coercive contracting with hospital-based physicians, increased pharmacy risk-bearing for physicians, and a number of proposed educational areas for medical staff members.

National level talks focused in large part on formation by the AMA of a national collective bargaining organization. The OMSS took a position in favor of this effort, feeling that such an organization should represent employed physicians in professional practice and resident and fellow physicians, and continue to vigorously support and seek antitrust relief for self-employed physicians. Essentially, these factors were incorporated into the position adopted by the AMA House of Delegates. Nationally, the AMA-OMSS gave close consideration to membership concerns and focused particularly on young physician involvement. A number of activities will be pursued to encourage young physician participation as well as fuller participation by other factions of the physician population.

In line with membership efforts, close scrutiny is being given to the mission, goals, and objectives of the OMSS; its principles, purpose, and organizational structure; interaction, bonding, dialogue and support of OMSS subgroups; and interface and interaction between local and state OMSS efforts and those of the AMA.

At the home level, the OMSS has become involved, along with the Jefferson County Medical Society, in a situational evaluation of carrier coding practices. There is continuing concern, which most physicians share, over possible instances of "downcoding" by insurance carriers, insufficient notification to billing physicians of coding changes, inconvenient documentation requirements, and possible arbitrary or unknown carrier audit criteria. These are not new concerns, but are certainly relevant and, fearfully, may be growing.

Meetings have been routinely held by the Jefferson County Medical Society with carriers to discuss these and related issues, and the OMSS has participated in discussions with Humana. As a result of these discussions, an open forum "town meeting" has been scheduled with Humana representatives that will occur before the Annual Meeting. It is hoped that this forum will result in at least a better understanding of carrier practices, as well as communication of medical practice difficulties faced by physicians. While a distinct resolution of all concerns is probably unlikely, this type of communication can hopefully help physicians have a better understanding of carrier administrative practices and documentation criteria.

John D. O'Brien, MD
Chair

Rural Kentucky Medical Scholarship Fund, Inc

The Rural Kentucky Medical Scholarship Fund, Inc. (RKMSF) attempts to meet the medical needs of the rural population by alleviating the maldistribution of physicians in Kentucky. RKMSF currently administers two worthwhile programs in its efforts to meet this goal.

The first program provides low interest loans to medical students. Any loan recipient who practices primary care medicine in a county in critical need of physicians will be forgiven one loan for each full year of practice in the approved county. Any recipients practicing in a designated rural county facing a primary care physician shortage which is less than critical must repay their loans at a discounted interest rate which is determined yearly. Interest accrues from the date of the loan until the loan is paid in full.

Due to a significant increase in applicants, the Fund was required to limit the number of loans to new applicants to 12 for the 1999-2000 academic year. This year's new recipients, including 21 prior student recipients, received loans in the amount of \$12,000 each. For the last two academic years, loans have totaled \$396,000. There was \$312,000 expended in loans in the 1997-98 academic year.

Since its inception in 1946, the Rural Kentucky Medical Scholarship Fund has granted approximately 713 loans. In 1999-2000, the Fund will have 9 graduating seniors entering primary care residency programs; 3 recipients

are currently enrolled in residency programs; and 9 recipients are entering the full-time practice of medicine in 1999. There were 8 recipients who received forgiveness of loans in 1998-99 and 6 recipients completed their financial and/or practice obligations in 1998-99.

The second program administered by RKMSF is the Establish Practice Grant Program (EPGP). The EPGP provides money to physicians entering practice in an area in critical need of physicians to help alleviate the financial burden of practicing in such an area. In order to make the Program more enticing to potential applicants, the Fund increased the amount of a single grant to \$12,500 and eliminated the requirement that grant money be used towards paying educational loans. For each year a physician in the EPGP practices in a critical county, he receives one grant, with a maximum of \$50,000 granted per physician.

One physician is currently participating in the EPGP. Since its inception in 1989, there have been a total of 9 participants in the EPGP. Currently, there are 4 vacancies in the Establish Practice Grant Program.

The Kentucky Medical Association continues to provide financial and other support to the RKMSF which greatly contributes to the success of the Fund. The RKMSF, while operated through the KMA, is a separate, nonprofit corporation, having its own officers and Board of Directors. This report is furnished as an informational item.

Donald R. Stephens, MD
Chair

END OF CONSENT CALENDAR ITEMS

Cancer Committee

The Cancer Committee's purpose is to promote the continuing study of patient screening, prevention, education, and treatment of the disease of cancer. The committee serves as a liaison with medical schools, cancer treatment centers, and the Kentucky Chapter of the American Cancer Society.

The committee continued its focus this year on the issue of mastectomy vs breast conservation procedures. A few years ago, Kentucky was ranked 50th in the nation with the lowest rate of breast conservation, according to Medicare data. Early on it was determined that patient and physician bias seemed to be the most important factor in the decision for treatment of breast cancer. Since that time, many individuals and groups have emphasized appropriate breast cancer treatment, and this trend has somewhat abated. In an attempt to determine the degree of improvement in this trend, aside from anecdotal or empirical information, individual committee members have been involved in focused studies. Specifically, members in Louisville, Lexington and Paducah conducted local research.

Where earlier one of the prime determinants of procedure of choice was the surgeon's recommendation, with the expansion of radiation oncology and enhanced pathology procedures, it would seem that this trend is changing. Other factors also appear to pertain. While the primary surgeon's recommendation remains a major determinant of procedure of choice, routine referrals for radiation therapy and medical oncology consultation are influential, as is an increasingly sophisticated public. In local areas multidisciplinary groups within hospitals have also been formed to address the issue. Obviously, geographical site of treatment plays a major role.

To briefly recap the reports cited, a telephone survey was administered to 132 women who underwent surgical treatment for breast cancer in Louisville. The survey consisted of 32 questions relating to diagnosis and treatment options. The results of this study were that 85% of the women chose mastectomy. Of these women, 35% based their choice on the surgeon's recommendation.

In Paducah, 50 women who received breast cancer surgery were surveyed. Of those responding, 58% selected mastectomy only, and 50% of those patients indicated their decision was based primarily on the surgeon's recommendation. The other half based their decision on information received from other sources. Of those responding, 67% received a copy of the breast cancer book available in physicians' offices. Of those who underwent surgery, all felt they were adequately informed and were pleased with the surgical outcome.

As a general trend, more than 50% of breast cancer patients are referred for radiation consults in one Lexington site, and fewer than 30% receive mastectomy only. Approximately 50% of those who receive mastectomy will also have reconstructive procedures performed.

The committee directed information on this issue to the Kentucky Chapter of the American College of Surgeons and the Kentucky Academy of Family Physicians in an effort to raise the awareness of this clinical practice pattern.

This year the committee endorsed, and several committee members participated in, the Primary Care Provider Project. This project, conducted by the Kentucky Cancer Program, was intended to increase breast and cervical cancer screening awareness and occurrence among Kentucky women through CME programs and office-based interventions for primary care physicians. The project consists of a self-study packet that includes a video, a White Paper outlining standards of practice, breast and cervical cancer screening recommendations, sample office tools, a post-test, and an evaluation.

Several physicians in the state were privileged to have participated in the planning of this program, and some helped prepare and appeared in the video. KMA approved use of the kit for two credit hours of continuing medical education, and the Kentucky Medical Insurance Company offered a discount on liability insurance premiums for completion of the program. As of December 1998, over 450 orders were received, and post-tests and evaluations were beginning to be returned. In further follow-up, the Kentucky Cancer Program has approached managed care groups and asked them to provide pre- and post-review data. It is appropriate at this point to recognize the Kentucky Cancer Program, which has done an excellent job in the production of this kit. In addition, under the very able leadership of Ms Connie Sorrells, the Kentucky Cancer Program continues to act as a very valuable coordinator of many cancer activities. The committee is privileged to have Ms Sorrells serve as an ex officio member.

This year the committee also considered the benefits and possibilities of developing a cancer screening registry. One of the most alarming facts evident from information in the cancer registry is that in Kentucky cervical cancer is a major health problem, and sites in Kentucky report the highest incidence of cervical cancer in the country. One of the committee members is currently attempting to develop a research project and seek grant funding to disseminate information about cervical cancer. The Kentucky Cancer Program currently is working to develop local coalitions to raise community awareness, and a limited amount of funds from the Centers for Disease Control are being donated to this effort in targeted high-risk areas.

The Division for Adult and Child Health within the Cabinet for Health Services oversees some cancer screening services for eligible state recipients through local health departments, but also through the medical centers and the Kentucky Cancer Program. This issue is also being scrutinized by the Governor's Task Force on Breast Cancer which is currently chaired by a committee member, Gilbert H. Friedell, MD.

While the state encourages screenings through health departments where individuals must undergo cervical screening to obtain contraceptives, extension of this service to women beyond childbearing age, those most often susceptible, is not as effective. Likewise, the Kentucky Cancer Program is active in collaboration with screening sites in over 30 counties, but some rural areas do not have facilities available for these services. Unfortunately, the issue of cervical screening appears to contain a social stigma not attached to breast cancer and other general women's health issues.

The committee sees this overall issue as a significant concern, particularly considering that cervical cancer is one of the most successfully treated diseases when coupled with proper screening. To this end, the committee is in the process of referring the matter to a subcommittee for focused consideration to identify priorities in dealing with cervical cancer screening, diagnosis and treatment and how to best use limited resources available. While optimal care is an obvious goal, minimal standards should probably be identified. Together with the work of this subcommittee, the Cancer Committee feels that the issue is deserving of special attention by the Association, and feels that the topic of cervical cancer should be the subject of a plenary session for the next Annual Meeting. The committee would like to make this recommendation for consideration.

Several individuals on the committee were pleased to participate this year on the previously mentioned Breast Cancer Task Force established by Governor Patton to develop a breast cancer action plan. This group consists of over 60 members, has met several times, and has developed recommendations for action by the Governor and the legislature.

It has been the feeling of many individuals involved with the task force that further definition is needed in areas such as data collection and devel-

opment of standards, and a one-year extension of the task force's work is being sought. These include the development of a statewide mammography registry that could be linked to the Cancer Registry and a database thereby developed. Some of the efforts and recommendations of this group apply to cervical cancer, and parallel the concerns of this committee.

The committee will continue its work in the areas currently under consideration and, obviously, will develop further ones. As chairman, I would like to express my sincere thanks to the members for their efforts on behalf of KMA as well as their individual activities related to this significant disease.

Michael J. Edwards, MD
Chair

RECOMMENDATIONS:

1. The Cancer Committee recommends that a plenary session of the Annual Meeting be devoted to issues related to cervical cancer or that this matter receive some other appropriate address within Annual Meeting activities.

RECOMMENDATIONS, REFERENCE COMMITTEE B:

Reference Committee B reviewed Report No. 15 and its Recommendation. Reference Committee B recommends the report and its Recommendation regarding a plenary session on cervical cancer be adopted.

RESOLUTION 99-101

UL Off Campus Teaching Center at Trover Foundation Hopkins County Medical Society

WHEREAS, the University of Louisville School of Medicine Off Campus Teaching Center (OCTC) based in Madisonville, Kentucky, at Trover Foundation was established by the Governor's Executive Order in 1992; and

WHEREAS, the purpose of the OCTC is to encourage medical students to consider careers in primary care and effect a better distribution of physicians in Kentucky; and

WHEREAS, full funding of the OCTC is supported by the Kentucky Academy of Family physicians; now therefore, be it

RESOLVED, that the KMA should work with the University of Louisville, appropriate members of the Kentucky General Assembly, and the Governor of the Commonwealth of Kentucky to assure adequate funding for the University of Louisville Off Campus Teaching Center at the Trover Foundation in Madisonville.

RECOMMENDATIONS, REFERENCE COMMITTEE B:

Reference Committee B reviewed Resolution 101, UL Off Campus Teaching Center at Trover Foundation, submitted by the Hopkins County Medical Society. Considerable discussions were held and questions were answered by William J. Crump, MD, Assistant Vice President and Associate Dean for Health Affairs, UL Off Campus Teaching Center of the Trover Clinic Foundation.

Reference Committee B recommends that the Resolved be amended by replacing the words "work with" with the word "encourage." The Resolved will then read:

RESOLVED, that the KMA should ~~work with~~ encourage the University of Louisville, appropriate members of the Kentucky General Assembly, and the Governor of the Commonwealth of Kentucky to assure adequate funding for the University of Louisville Off Campus Teaching Center at the Trover Foundation in Madisonville.

Reference Committee B recommends that Resolution 101 be adopted as amended.

RESOLUTION 99-104

Mandatory Hospitalist Programs Board of Trustees

WHEREAS, a "hospitalist" is a physician employed by a hospital, insurance company, or health maintenance organization who works in a hospital setting and serves as the physician-of-record after accepting hospitalized patients from primary care physicians, returning the patients to the care of the primary care physicians at the time of the hospital discharge; and

WHEREAS, the use of hospitalists is becoming more popular around



the country in markets with a large managed care penetration; and

WHEREAS, there are advantages to using hospitalists including accessibility, familiarity with hospital bureaucracy, and experience treating acutely ill hospital patients; and

WHEREAS, hospitalists also may not know the medical history of the patient as well as the patient's primary care physician; and

WHEREAS, the use of hospitalists may lead to communication problems among the primary care physician, consultants, the hospitalist, the patient, and the patient's family; and

WHEREAS, the use of hospitalists is still being tested and is not commonplace in the medical industry; and

WHEREAS, physicians and their patients should have the choice as to whether they would like care to be assumed by a hospitalist when the patient is in the hospital; and

WHEREAS, in Florida, one insurance company has instituted a mandatory hospitalist program in which physicians must turn over care of patients to hospitalists when the patients are put in the hospital; and

WHEREAS, the mandatory use of hospitalists is an effort to take patients away from their chosen physician involuntarily, which violates the physician/patient relationship; now, therefore, be it

RESOLVED, that the Kentucky Medical Association oppose all mandatory hospitalist programs as an infringement on the physician/patient relationship and support legislation that prohibits mandatory hospitalists programs.

RECOMMENDATIONS, REFERENCE COMMITTEE B:

Reference Committee B reviewed Resolution 104, Mandatory Hospitalist Programs, submitted by the Board of Trustees. Reference Committee B recommends that Resolution 104 be adopted.

RESOLUTION 99-126

Pap Smears

Fayette County Medical Society

WHEREAS, Kentucky has a high incidence of cancer of the cervix; and
WHEREAS, cancer of the cervix is preventable by early detection; now, therefore, be it

RESOLVED, that all health insurance carriers be required to pay for Pap smears according to American Cancer Society guidelines, in conjunction with other national society standards, at a rate that reflects actual laboratory costs.

RESOLUTION 99-127

Colorectal Cancer Screening

Fayette County Medical Society

WHEREAS, colorectal cancer death rate is decreased by early detection; and

WHEREAS, Kentucky colorectal cancer rates exceed the US median; now, therefore, be it

RESOLVED, that all health insurance carriers be required to pay for colorectal cancer screening according to American Cancer Society guidelines, in conjunction with other national society standards, at a rate that reflects actual laboratory costs.

RESOLUTION 99-134

Cervical and Colorectal Cancer Screening

Board of Trustees

WHEREAS, Kentucky has a high incidence of cancer of the cervix, which is preventable by early detection; and

WHEREAS, the colorectal cancer death rate is decreased by early detection, and Kentucky colorectal cancer rates exceed the US median; now, therefore, be it

RESOLVED, that all entities that serve as payers for medical services should be required to include cervical and colorectal screening, in accordance with nationally accepted standards, as covered services to be reimbursed at a rate that reflects the cost of the procedure and the professional service provided.

RECOMMENDATIONS, REFERENCE COMMITTEE B:

Reference Committee B reviewed Resolution 126, Pap Smears, submitted by the Fayette County Medical Society; Resolution 127, Colorectal Cancer Screening, submitted by the Fayette County Medical Society; and 134, Cervical and Colorectal Cancer Screening, submitted by the Board of Trustees; together, due to their similar subject matter. Reference committee B recommends that Resolution 134 be adopted in lieu of Resolutions 126 and 127.

RESOLUTION 99-129

Cancer Screening

Board of Trustees

WHEREAS, cervical cancer is a significant health issue and certain sites in Kentucky have the highest incidence of this disease in the country; and

WHEREAS, breast cancer is the second leading cause of cancer deaths among women; and

WHEREAS, survival rates for both forms of cancer are significantly enhanced by early screening and treatment; and

WHEREAS, a number of efforts are under way to confront all aspects of these diseases by the state cancer centers, the Kentucky Cancer Program, state agencies and many individual physicians; and

WHEREAS, the KMA Cancer Committee leads a concern shared by many physicians for improved cancer screening and enhanced screening registration procedures, as well as increased focus on these diseases, which are both potentially fatal and treatable; now, therefore, be it

RESOLVED, that KMA recognizes the necessity for and supports the expansion of cancer screening and the full development of a screening registry as acknowledged by the KMA Cancer Committee; and be it further

RESOLVED, that KMA supports all appropriate efforts by affected agencies to direct actions and to obtain and coordinate necessary resources to develop an effective, comprehensive screening registry.

RECOMMENDATIONS, REFERENCE COMMITTEE B:

Reference Committee B reviewed Resolution 129, Cancer Screening, submitted by Board of Trustees. Reference Committee B recommends that Resolution 129 be adopted.

RESOLUTION 99-130

Kentucky Breast Cancer Task Force

Board of Trustees

WHEREAS, breast cancer is the second most common cause of cancer-related death among women in Kentucky; and

WHEREAS, early detection is a key element of effective treatment and improved survival for breast cancer, although one-third of all breast cancer cases in the state are diagnosed in late stages; and

WHEREAS, Governor Paul E. Patton established the Kentucky Breast Cancer Task Force in 1998 to assess the availability, use, and outcomes of breast cancer screening and treatment services; the adequacy of insurance coverage; needed services; use of federal and state funding; and availability and use of treatment data; and

WHEREAS, this Task Force included representatives of medical specialties, cancer treatment facilities and coordinating organizations, advocacy groups and the Kentucky Medical Association's Cancer Committee; and

WHEREAS, this Task Force has developed several strongly useful recommendations for improving the detection and treatment of cancer, and the enhanced use of medical and financial resources to be made to the Governor and the Legislature; now, therefore, be it

RESOLVED, that this Association does commend Governor Paul E. Patton for his leadership in creating the Kentucky Breast Cancer Task Force, his stewardship in promoting its work, and his statesmanship in bringing increased focus on these critical issues; and be it further

RESOLVED, that KMA supports the efforts of the Task Force and its recommendations for improving cancer detection and treatment; and be it further

RESOLVED, that KMA commends all of the individuals who have contributed to this important work and gratefully recognizes the efforts of members of the KMA Cancer Committee in this endeavor.

RECOMMENDATIONS, REFERENCE COMMITTEE B:

Reference Committee B reviewed Resolution 130, Kentucky Breast Cancer Task Force, submitted by Board of Trustees. Reference Committee B recommends that Resolution 130 be adopted.

Mr Speaker, I recommend the adoption of the report of Reference Committee B as a whole.

Mr Speaker, I would like to personally thank the other members of Reference Committee B who have assisted in the formulation of this report. The other members of the committee were: Charles Bea, MD, Mayfield; James F. Beattie, Jr, MD, Bowling Green; Daniel E. Kenady, Sr, MD, Lexington; Molloy G. Veal, MD, Louisville; and James E. Wheeler, II, MD, Madisonville. I also want to personally thank Ms Hope Proctor for her assistance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE B
Ronald E. Walldridge, II, MD, Shelbyville, Chair
Charles Bea, MD, Mayfield
James F. Beattie, Jr, MD, Bowling Green
Daniel E. Kenady, Sr, MD, Lexington
Molloy G. Veal, MD, Louisville
James E. Wheeler, II, MD, Madisonville

Editorial Note: Unless otherwise indicated, the reference committee recommendation on each report and resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE C

Lela C. Maynard, MD, Pikeville, Chair

19. Report of the Maternal Mortality Study Committee
 20. Report of the Committee on National Legislative Activities
 21. Report of the Committee on State Legislative Activities
 22. Report of the Committee on Professional Liability Insurance
 23. Report of the Committee on Care of the Elderly
 24. Report of the Public Education Committee
 25. Report of the Committee on Complementary and Alternative Therapies
- Resolution 103 — Repeal of Stark Law
(Board of Trustees)
- Resolution 105 — Determination of Medical Necessity
(Board of Trustees)
- Resolution 113 — Repeal Free Medical Record Mandate
(Jefferson County Medical Society)
- Resolution 115 — Anti-Trust Relief
(Jefferson County Medical Society)
- Resolution 116 — Out-of-Network Benefits
(Jefferson County Medical Society)
- Resolution 128 — State Action Doctrine
(Board of Trustees)
- Resolution 131 — National Patient Protection Legislation
(Board of Trustees)
- Resolution 132 — Out-of-Network Benefits
(Board of Trustees)

ITEMS FOR CONSENT

Reference Committee C reviewed the following items and recommends they be filed, by consent of the House, without discussion:

19. Report of the Maternal Mortality Study Committee — filed
20. Report of the Committee on National Legislative Activities — filed
22. Report of the Committee on Professional Liability Insurance — filed
23. Report of the Committee on Care for the Elderly — filed
24. Report of the Public Education Committee — filed
25. Report of the Committee on Complementary and Alternative Therapies — filed

Mr Speaker, Reference Committee C would like to express its appreciation to the authors for their efforts in preparing these reports for the House of Delegates. Reference Committee C recommends the adoption of the Consent Calendar as a whole.

Maternal Mortality Study Committee

The Maternal Mortality Study Committee of the Kentucky Medical Association met once during the organizational year on September 23, 1998. The committee discussed the procedures for the reporting of a maternal death. These include communications with the Chair's office at (502) 852-5811 for members to report a maternal death. An alternative method is for a member of the committee, which at this time is John Petry, MD, to review all Kentucky death certificates looking at deaths of women aged 15-50 who have been pregnant within the last year. The current death certificate has a box for the physician to check whether the patient has been pregnant within the last year. When a maternal death is reported, Dr Petry will review the records pertaining to the pregnancy, delivery, and death of the mother and record the data on newly developed forms from the Michigan Maternal Mortality Committee that have been modified for our use.

The committee then discussed six maternal deaths reported to the committee. A number of these deaths were from years other than 1998. This delay in reporting deaths to the committee is caused by a delay in the identification of maternal deaths, impending litigation, and/or incomplete records. The six maternal deaths reviewed at this meeting include three from 1996, one from 1997, and two from 1998. All of the deaths were obstetrical deaths. Two deaths were caused by amniotic fluid embolism and these were judged to be nonpreventable. One death was due to a cardiomyopathy and this was judged to be nonpreventable. One death was caused by cardiac arrest secondary to hypertension in a patient who had no prenatal care and was found dead at home. This was a nonpreventable death, although there was responsibility on the part of the patient. There were two maternal deaths that were preventable. Both were due to sepsis and hypovolemia.

In summary, we reviewed six maternal deaths with two secondary to amniotic fluid embolism judged nonpreventable, one due to cardiomyopathy judged nonpreventable, one due to hypertension and cardiac arrest judged nonpreventable, and two second to septic shock and hemolytic shock which were judged to be preventable.

The committee is planning to submit case reports to the *Kentucky Medical Association Journal*.

Stanley A. Gall, MD
Chair

Committee on National Legislative Activities

On June 8 and 9, a delegation from the Kentucky Medical Association visited the Kentucky Congressional Delegation in Washington. The KMA delegation included William P. VonderHaar, MD, Louisville; J. Gregory Cooper, MD, Cynthiana; Andrew R. Pulito, MD, Lexington; William B. Monnig, MD, Edgewood; John E. Downing, MD, Bowling Green; your Chair and KMA staff. On June 8, the delegation visited AMA Headquarters for a briefing from AMA lobbyists. The highlight of the trip was lunch and a legislative update with Congressman Ernie Fletcher, MD, and his staff. Following that meeting we met with Senator McConnell's staff and with Senator Jim Bunning. On June 9 we visited Congressmen Ed Whitfield, Ron Lewis, Anne Northup, Ken Lucas, and Hal Rogers.

The KMA group concentrated on the following issues.

- Patient Protection
- Antitrust Relief for Physicians
- Fraud and Abuse Reforms
- Medical Necessity Definition
- Privacy of Medical Records

(1) PATIENT PROTECTION

- Independent external review and appropriate appeals process
- Definition of, and who determines, "medical necessity"
- Emergency services provisions
- Comprehensive ban on gag clauses and gag practices
- Patient access to pediatric, obstetrical, and other specialist care
- Require health plans to be accountable for demonstrated injury or death resulting from their negligent medical decision-making
- Permit stronger patient protections passed by states to remain in force
- Point-of-service option

(2) ANTITRUST RELIEF FOR PHYSICIANS

We strongly supported "The Quality Health-Care Coalition Act of 1999"



(HR 1304—the Campbell bill). The Campbell bill corrects the imbalance in power by allowing groups of physicians to engage in joint negotiations with health plans. Physicians could agree not to contract individually with a health plan unless a satisfactory contract is negotiated with that plan by the group. This would allow physicians to act as a check on unrestrained health plan leverage. We are pleased that both Congressman Fletcher and Congressman Whitfield signed on as co-sponsors.

(3) FRAUD AND ABUSE REFORMS

We believe that fraudulent behavior has no place in the practice of medicine, and in no way do we condone fraudulent activities by physicians. However, the fraud and abuse mantra is attached to almost every Administration or congressional initiative that saves money for Medicare. We asked our delegation's support for the following provisions.

- HCFA should not create the payment error prevention program (PEPP) as part of the peer review organizations (PROS)
- HCFA should not encourage carriers to ask physicians to waive their rights to appeal during post-payment audits
- Physicians should have an administrative right of action against carriers who make errors that significantly harm physicians

(4) MEDICAL NECESSITY

The KMA urged support for legislation that incorporates the following principles:

Prudent physicians must be able to make medical necessity decisions for their patients, without unreasonable interference from health plans for insurers.

KMA Medical Necessity Definition

- Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (1) in accordance with generally accepted standards of medical practice (2) clinically appropriate in terms of type, frequency, extent, site, and duration and (3) not primarily for the convenience of the patient, physician, or other health care provider.
- Patients should not be treated unfairly by health plans or insurers, by denying coverage for medically necessary treatment, based on information the plan or insurer obtains only later in the course of treatment.
- Medical necessity should be determined according to a "prudent layperson standard," which legally and medically is an objective standard—not subject to the abuse that is often alleged or asserted by plans and insurers. Assertions that "medical necessity" standards would lead to requiring insurers to pay for health clubs is a "red herring."

(5) PRIVACY OF MEDICAL RECORDS

- We advocated the basic right of patients to privacy of their medical information and the right to control access to this information with narrowly drawn exceptions made in the public interest. We supported the following changes to S 578 which is presently being considered by the Senate Health, Education, Labor and Pensions Committee, which is addressing privacy of medical records.
- The legislation presently establishes a federal "ceiling" approach to pre-emption, which would supercede even more protective state law. We support a federal "floor" in establishing standards for protecting patient medical information.
- We opposed a provision that would require a patient to sign a consent form as a condition of enrollment in a health plan or to receive care. How can this be perceived as "consent" if the "consent" is extracted by the threat of not being treated or of one's dependents not having insurance coverage.
- The KMA believes that law enforcement agents should only have access to personally identifiable medical information when acting through a court order or similar instrument obtained under a "clear and convincing" evidentiary standard.

We were extremely impressed with the knowledge of patient protection and health related legislation by Kentucky Senators and Congressmen. In addition, we are "cautiously" optimistic that some form of patient protection will pass this year. Unfortunately, there is a great deal of politics being played over this issue. Sources on Capitol Hill tell us that the Republicans and Democrats both appear to oppose passage of patient protection in 1999. While Republicans have philosophical problems with some aspects

of AMA's proposals, the Democrats simply plan to use the defeat of patient protection legislation for campaign fodder in the 2000 congressional races.

A Bipartisan Commission to reform Medicare broke down as a result of demand for additional coverage, specifically prescription drug coverage. While some Commission members supported some Medicare expansion, that support came with a demand that a "means test" be required for those financially capable of paying for prescriptions. However, AARP has traditionally opposed any effort to inject means testing into Medicare. In addition, there was considerable support to provide Medicare recipients various options, based upon their ability to pay. It appears that incentives to reform Medicare and Social Security have been placed on the back burner due to recent reports from the two major federal entities. According to Senator William Roth, Chairman of the Senate Committee on Finance, Medicare's Hospital Insurance Trust Fund, which pays inpatient hospital expenses, is projected to be able to pay benefits until 2015, seven years longer than the Trustees projected in 1998. In addition, the Social Security trust funds are projected to be adequately financed until 2034, two years later than projected in 1998.

Physicians became highly incensed at HCFA's efforts to engage Medicare beneficiaries and their families in a nationwide effort to uncover provider fraud and abuse. The scheme was based upon an OIG report stating, "that as much as 10% of Medicare charges are fraudulent." This number (10%) was generated by the GAO in the early 1980s as an estimate. In fact, the OIG still cannot distinguish between inadvertent mistakes and outright fraud and abuse.

Finally, Kentucky's Congressional Delegation was extremely supportive of KMA and other associations' efforts to defeat an administrative proposal to tax association income from interest, dividends, rents and royalties. Under the plan, the first \$10,000 an association earned from interest, dividends, rents and royalties would not have been taxed. However, all income earned over \$10,000 would have been subject to the unrelated business income tax (UBIT). If adopted, this proposal would have had a devastating impact upon non-profit associations' ability to promote public programs such as the Kentucky Physicians Care program, Rural Kentucky Medical Scholarship, and other similar public benevolent projects.

As this report is written, resolution of the Federal Budget is still not settled. Patient Protection, fraud and abuse, Medicare reforms, and other issues of interest to physicians are often tied up in the final budget settlement. We are delighted that our colleague, 6th District Congressman Ernie Fletcher, MD, is in Washington. Ernie is a fine physician and his experience in the "give and take" of Frankfort, especially as it relates to health care reform, should be extremely beneficial to him in Washington.

In closing, the committee expresses appreciation to all members of KMA for their support by writing letters, making phone calls, and speaking personally with their elected representatives. We should never forget that while politics can be extremely difficult, our system of government rests upon the interaction that takes place between constituents and elected officials.

Donald C. Barton, MD
Chair

Committee on Professional Liability Insurance

The Committee on Professional Liability Insurance is composed of the KMA Executive Committee and the Chair of the KMA Committee on State Legislative Activities. While the committee did not meet during the year, there was action on the liability front at both the state and national levels.

On the state level, the Kentucky Supreme Court ruled that state employees have broad protection from liability under the sovereign immunity doctrine. This may expand protections for physicians employed by the state, although the ramifications of the court's decision are still unknown.

Another decision by the Kentucky Supreme Court that directly affected physicians was the court's opinion that peer review records are subject to discovery in malpractice actions. Despite KMA's persistent efforts to pass legislation over the last 20 years to provide protections for peer review records, the court has consistently overturned those protections despite the will of the Kentucky General Assembly. In its latest opinion, the court hinted that no matter what the legislature does, the court will hold that such records

are discoverable. KMA legal counsel prepared a paper on the opinion, which tells physicians what they can and cannot do to protect peer review records, and KMA also cosponsored a seminar on the issue.

The committee is preparing for the upcoming legislative session in January 2000, and will continue to push for some type of tort reform in Kentucky. In addition to a constitutional amendment to allow passage of tort reform in Kentucky, it is anticipated that the General Assembly will debate whether HMOs should continue to have immunity from lawsuits. The same debate has also occurred on the national level and KMA, along with the AMA, supports HMOs being held accountable, just as physicians are held accountable for their actions.

Wally O. Montgomery, MD
Chair

Committee on Care of the Elderly

The Committee on Care of the Elderly is responsible for investigating, monitoring trends in, and suggesting actions for KMA about the spectrum of care for the elderly; for conducting liaison with elderly advocacy groups; and for communicating issues about the elderly to the membership. To fulfill this responsibility, the committee has periodically conducted forums on issues of concern to all principal groups to receive input and hopefully acquire consensus and involvement.

This year the committee conducted a seminar entitled, "Driving the Elderly: Issues and Answers for the Aging Driver." This topic was chosen because it has impact on the health and well-being of the elderly from several different perspectives.

In planning the seminar, the committee sought presentations from individuals representing organizations with varying responsibilities for the aging population. It was hoped that the entire group could interchange information and benefit from communications exchange. To this end, presenters gave information from the standpoint of medical practice; the Division of Aging of the Cabinet for Families and Children; the American Association of Retired Persons; the Department of Transportation's Medical Review Board; law enforcement, as represented by the Kentucky State Police; and the state legislature.

The committee was fortunate in soliciting an educational grant for the seminar from Parke-Davis and received designation from KMA for three hours of Category 1 continuing medical education credit. Attendees at the seminar included physicians, nurses, law enforcement agencies, elderly advocate groups, social workers, and workers from local Division of Aging offices.

To fulfill its responsibilities as designated by the Board of Trustees, the committee submits the following information developed from the seminar for the benefit of the members.

Overview

Driving is a major fact of life for the elderly, affecting independence, emotional well-being, and viability. It also has implications for everyone with responsibility associations to the elderly. Physicians must balance physical and psychological health with the safety and welfare of elderly patients. Law enforcement is concerned with the safety of society overall vs the rights of individuals. Advocacy groups are obligated to support driving rights for the able elderly and help the unable to relinquish rights. Legislatures are finally responsible to consider the priority needs of all.

Medical Perspective

Driving is clearly a medical issue. There are documented effects of aging on physical function, as well as the effects of various medical illnesses on driving. Clinical factors are known that may predict driving mishaps. Aging is associated with inevitable physiological change, increased rates of disability, increases in chronic diseases, and higher use of medications.

Age-related conditions that may increase medical risk for driving are: changes in vision, decreased reaction time, hearing loss, slowed nerve transmission, and declination of muscle mass and grip strength. Common disorders among the aging that may increase risk are arrhythmia, chronic obstructive pulmonary disease, sleep apnea, diabetes, seizures, dementia, Parkinson's disease, polypharmacy, alcohol use, and arthritis. In one study reported in the *Journal of American Geriatrics* coronary heart disease was established as the highest risk factor for elderly driving mishaps. Another major medical condition affecting driving is dementia. It has been reported

that 50% of all persons over the age of 85 have some degree of dementia.

Drug use is also a potential predictor of driving mishaps. It has been reported that individuals are 50% more likely to have a driving accident while taking benzodiazepines. Other predictors of driving mishaps in the elderly are limited neck rotation, poor visual attention and acuity, and foot abnormalities.

Physicians should routinely speak with older patients about driving patterns, "near misses," and falls; should routinely review medication and counsel on its effects; should not focus on the diagnosis itself, but rather on function; and should attempt to evaluate cognition and visual/spatial skills and attention.

Law Enforcement

It is a tenet in law enforcement circles that all vehicular accidents are caused by people. While one in every nine persons will be involved in a vehicular mishap each year, surveys show that 30% of people believe that their chances of being involved in a crash are 1 in 1,000. While younger drivers have more accidents by volume, elderly drivers operate vehicles much less often, but have more fatalities per miles driven. It is the responsibility of law enforcement to balance the safety of the public and individual rights.

Any licensed driver can request and complete an affidavit for recertification on any other driver. Physicians can complete such affidavits by contacting the Medical Review Board at the Department of Transportation. Such affidavits cause the Medical Review Board to initiate a review and evaluation and make the board responsible for a final determination on driving restriction or suspension. This information is relevant because, since 1975, fatal accidents have increased 38% in the age group of 75 and older.

Other dynamics contributing to driving mishaps in the elderly population are that this population is increasing, it is more affluent than in the past, and most elderly own automobiles. Public transportation statewide is sparse or nonexistent.

It is well known in law enforcement circles that, over the age of 45, night vision wanes and visual and aural reaction is 79% slower, with increasing diminution. Because of these physical factors, law enforcement authorities usually do not give "divided attention" tests to drivers 60 years of age or older.

More research is needed to determine specific identifiable and treatable problems and to develop reasonable assessment techniques to discover these problems. Regardless, driving capabilities should be determined on the basis of function, and not age.

The Kentucky State Police, along with other law enforcement agencies, operate a Driver Improvement Program, which is presented locally to various groups. Successful completion of this course can result in a reduction in insurance premiums from some companies. Further information on presentation of this program in local areas can be obtained by contacting the Kentucky State Police.

AARP

Independence is critical to the overall well-being of the elderly, and a portion of such independence is mobility. There are few consistent public transportation services available for the elderly. Driving must be a balance between safety and independence. Elderly advocacy groups support the improvement of drivers' screening for all ages based on function and driving record, not age. Most elderly drivers limit themselves as age progresses.

The American Association of Retired Persons (AARP) offers a program entitled, "55 Alive," which consists of driving education and self-assessment. In order to identify those unable to perform self-assessment, the AARP is seeking ways to coordinate with health professionals to develop criteria. Ideally, there should be a mechanism for the routine referral of patients for evaluation for driving capability, which would allow driving restrictions based on individual needs.

Other areas that could be expanded to assist the elderly driver include improving and enlarging roadway signage, improved roadway design, mandating the use of safety belts, and enacting more appropriate laws on handicapped parking. While it would be convenient to require periodic retesting based on age, such an effort would be inappropriate because the capability of operating a motor vehicle is dependent on function, not age.

Medical Review Board

The Medical Review Board of the Department of Transportation has been in operation since the early 1970s. Because only limited statutes apply directly to driving restriction issues, the Medical Review Board is required to peri-



odically develop its own guidelines for disease and other medical restrictions on driving based on the current opinions of the board and current medical knowledge at the time. An example for the need to periodically review restrictions is the fairly recent availability of implantable defibrillators.

To assist the board, driver evaluations are often required which must be performed by special therapists. Currently, the evaluation mandated by the board consumes six hours, which includes road tests of functional capacity to drive, tests for both vertical and horizontal field of vision, and diagnosis-specific tests of functional ability.

Because driving is a privilege, not a right, such evaluations, if required by the Medical Review Board, must be performed at the expense of the patients. Within these constraints, the board can impose a variety of restrictions on drivers that will still allow some motor vehicle operation. These restrictions can include distance from home, times of day, and types of roads that may be used. If related to the statistical age groups of motor vehicle mishaps, the youngest and oldest drivers should receive the closest focus.

The Medical Review Board considers approximately 300 cases per year, and routinely places restrictions on 75% of drivers they review over the age of 55.

More information on the Medical Review Board's activities can be obtained by calling the Drivers' Licensing Bureau of the Department of Transportation.

Division of Aging

It is imperative that physicians and other health and welfare oriented groups give closer attention to elderly driving issues. Given Kentucky's population, drivers 70 years of age and older will more than double within the next 25 years. The number of drivers over 85 will increase four to five times. Older drivers are driving more miles than in times past. Male drivers will increase their total annual mileage in vehicles 465% within the next 20 years, and females will increase their travel 500%. In the US and in Kentucky, automobiles remain the primary means of transportation.

Of all Kentuckians 65 years and older, 75% live where the automobile is the primary mode of transportation; 85% live in single-family homes, not apartment or community homes. Very often the elderly use automobiles more after retirement than during their working lives.

Given Kentucky's current and future mobility resources, it is obvious that public transportation is not the answer for the elderly driver. There are some efforts, however, that can be undertaken. Rather than taking any punitive measures to restrict driving by the elderly, efforts should be undertaken to improve the health and physical function of older citizens. Efforts should be devoted to reengineering automobile designs to increase abilities for night driving and better vision. Reengineering efforts involving highway design and signage should be pursued. The elderly should be given help in planning travel to determine best times of day and distances. Retirement planning should include the eventual cessation of driving. Volunteers should be utilized whenever possible and all elderly advocates should work individually and seek collective efforts to assist the elderly in making decisions about these issues.

Legislation

Finally, all problems identified and solutions proposed rely on the availability of resources. Practicality defines resources as the availability of funding and the authority and operational sources needed to implement solutions. As an example of the scope of the problem, the lack of adequate public transportation is part of a larger issue of poverty and housing needs. Highway reengineering and road improvements are directly related to taxes available for public highways and general highway use by all citizens.

To effect these changes requires consensus by all groups, who are then represented legislatively. Fortunately, "senior" citizens routinely are regular voters and provide a strong potential for effecting change. Communication, collaboration, and coordination among all affected groups help assure passage of all legislation needed to accomplish new directives. While specific factors affecting and relating to the elderly driver can be identified and solutions sought, any long-term resolution requires consensus and agreement by society as a whole.

The KMA Committee on Care of the Elderly is deeply indebted to the volunteer presenters at the seminar for the information they provided and the interaction they helped stimulate. These presenters were: Steven H. Smoger, MD, Louisville; Jerry Whitley, Director, Division of Aging; Philip

Hulsman, MD, Legislative Chairman, AARP; David R. Watkins, MD, Louisville, Medical Review Board; Trooper John Bradley, Kentucky State Police; and the Honorable Mary Lou Marzian (D-34), Kentucky General Assembly.

Manuel L. Brown, Jr, MD
Chair

Public Education Committee

On behalf of the Public Education Committee, I am pleased to present the final report of its activities during the 1998-99 year. The committee is extremely active and experienced a highly successful year. The committee met on two occasions this year and instituted several new programs in response to public and professional needs.

We began the new year by developing a campaign to defeat an amendment on the November ballot that would have permitted the Kentucky General Assembly to meet on an annual basis. We worked closely with the Kentucky Farm Bureau and approved an expenditure of \$25,000 to assist in the defeat of the "annual session" amendment. The yearly unlimited agenda, which the amendment would have permitted, was primarily responsible for the opposition to the proposal by KMA House of Delegates.

The committee's award-winning production, *MediScope*, continues to be a very successful publication. Distribution has been increased to include 1,350 organizations, in addition to over 125,000 copies mailed quarterly to KMA members. Our Public Relations consultant, Mr Glen Bastin, investigated data on Kentucky's public and private schools for the possibility of sending *MediScope* to each school, but was unable to determine the number of private schools in the state. It was determined that while *MediScope* is not appropriate for elementary students, public high school libraries will be added to the mailing list.

Several years ago, the Public Education Committee developed a web site. Presently, the web site receives approximately 8,000 hits per month. The *MediScope* web site is now linked with the KMA site, and the committee is exploring linkage with the state Public Health Department.

The committee's newest and most extensive project was the development of a new children's activity booklet. Previously, the committee had purchased similar booklets from the AMA Alliance and the KMA Alliance cooperated in the project by distributing them. The latest booklet, "Say Ahh," will be distributed by the KMA Alliance to schoolchildren in grades 1-3. Approximately 250,000 booklets were printed and prepared for distribution in the fall of 1999. The KMA Alliance is working with the Kentucky Department of Education to distribute the booklets in 120 counties.

Last July, the committee approved expenditures for a press conference in Frankfort extolling "Patient Protection Day." The press conference was held to promote AMA's efforts to obtain passage of patient protection legislation in Congress. The Public Education Committee conducted the press conference and the following related activities:

- Developed press kits
- Filmed the conference and provided satellite feed to all TV stations in and around Kentucky
- Phoned each radio station in Kentucky and provided audiotapes
- Mailed press releases to all newspapers
- Mailed or faxed every physician in Kentucky an announcement of the media event and provided talking points for discussion with local media or patients
- Prepared press conference "presenters"

The KMA Public Education Committee also financially supported an additional Alliance project this year. The project involved development of a flyer concerning osteoporosis that was furnished to the state's teachers for children to take home to their mothers on Mother's Day. The project, which was highly successful, was strongly supported and assisted by the Kentucky Department of Education.

Upon request by KMA staff, the committee agreed to purchase an LCD projector for use at headquarters and around the state. This equipment will enable physicians to make more innovative presentations in the various meetings conducted by the Association.

The 1998 KMA House of Delegates adopted "Future Search," KMA's long-term plan. The plan calls for the Board of Trustees to take KMA into the future and has charged the KMA Executive Committee to implement

its suggestions. Several KMA committees were assigned various projects to begin implementation of the long-range plan.

The Public Education Committee was asked to fund a brief videotape of activities of the KMA and Public Education Committee to be used by Trustees at hospital staff visitation programs. In addition, a video is mailed to each "prospective" KMA member. The committee approved the expenditure and "premiered" the video at its second meeting.

The committee was assigned a project to begin development of a "Patient Survey" which could be used by physicians. The survey would relate to questions patients are encouraged to ask of their physician. During the year we made several inquiries and requests for copies of surveys. Private companies declined our request citing "proprietary information" explanations. The committee will continue to research this project in the coming year.

The Public Education Committee was requested to assist small county medical societies in sponsoring mini-internship programs. These programs are very successful in large county medical societies including Jefferson, Fayette, and Northern Kentucky. The committee sent letters to county medical societies explaining how the program is operated, and encouraged them to consider the program. The committee offered its assistance to the societies. Mini-internship programs require extensive staff work and we plan to ask the Alliance to assist local medical societies interested in such programs.

"Future Search" also recommended that the committee track and promote free medical care programs and Kentucky physicians' participation in these programs. The summer edition of *MediScope* headlined physicians' efforts to provide care through the Kentucky Physicians Care program and other free clinics. The Committee applauds and recognizes Kentucky's physicians for their outstanding efforts in providing care for the needy.

As the reader will note, this has been an extremely busy year for the Public Education Committee. We are proud of the various projects we have funded and promoted, and look forward to an aggressive and exciting 1999-2000 year for the Association. The KMA will undertake several legislative proposals relating to patient protection and health and safety measures. The committee plans to support these and other measures that benefit our patients. On behalf of committee members and staff, we thank the Board of Trustees and House of Delegates for their support and assistance, and for presenting each of us an opportunity to serve the public and the profession.

Preston P. Nunnelley, MD
Chair

Committee on Complementary and Alternative Therapies

The Kentucky General Assembly Task Force on Complementary and Alternative Medicine has conducted monthly meetings since its inception. Presentations to the Task Force have been made by various promoters of alternative therapies including acupuncture, oriental medicine, herbal therapy, naturopathy, naturopathic physicians, aroma therapy, mind-body, hypnosis, homeopathy and others. Professional associations, including chiropractic, physical therapy, nursing, pharmacy, nutrition, and KMA have testified. In addition, boards of licensure including medical, pharmacy, and nursing have introduced comments to the task force. At this juncture, based on remarks by various Task Force members, acupuncture seems to be of primary interest. The Task Force is expected to present its final recommendations to the General Assembly in the fall.

In March the KMA conducted a four-page survey of family physicians and internists at the request of the Task Force. KMA surveyed 2,460 licensed practicing physicians, including 1,235 family practitioners and 1,225 internists. Approximately 450 physicians returned the survey. The survey sought opinions from primary care physicians on their training, use, or knowledge of complementary and alternative therapy. The survey results were broken out in categories such as family practice, internal medicine, and US or international medical graduates. In addition, the results delineate the various decades of medical school graduation from the 1940s to the 1990s. The survey, which will be published in the *KMA Journal*, was presented to the Task Force on June 25, 1999.

Committee member and Board of Medical Licensure member Donald J. Swikert, MD, briefed the committee on the position of the Board of Medical Licensure. Doctor Swikert discussed the recent Board policy statement

on complementary and alternative therapies. The Board statement is excellent, and if members have not read the policy statement, it is important that they do so.

The committee has determined that it could contribute immensely to the profession and its patients by providing written articles on the benefits and hazards of alternative medicine. These articles will be presented for publication in the *KMA Journal* and other KMA publications. A paper written by Doctor Swikert, who is also a member of the General Assembly Task Force, outlining an overall view of complementary and alternative therapy, has been submitted to the *Journal* Editorial Board. Following publication of that article, the KMA survey of primary care physicians will be presented.

In the coming year, committee members and staff will be monitoring newspapers, magazines, periodicals and other sources for articles on complementary and alternative therapy. In addition, each committee member has been asked to submit a list of the top ten alternative therapies of interest to him or her. Once we receive lists from members of the committee, we will decide which ten issues warrant the committee's attention.

The committee plans to complete this study in the coming year and will continue to report periodically to the membership through the various publications available to KMA. The committee is appreciative of the opportunity to serve and looks forward to a productive year.

Daniel W. Varga, MD
Chair

END OF CONSENT CALENDAR ITEMS

Committee on State Legislative Activities

The Committee on State Legislative Activities met once during the 1998-99 Association year. That meeting lasted approximately 4 1/2 hours due to the large number of referrals from the Board of Trustees.

Resolution 98-120, "Annual Session Amendment," was referred to the committee by the 1998 House of Delegates. The resolution directed KMA to oppose the constitutional amendment placed on the November ballot to permit annual sessions of the Kentucky General Assembly. With financial assistance from KMA and Kentucky Farm Bureau, the amendment was defeated.

Resolution 98-112, "Health System Reform," submitted by the Fayette County Medical Society, was referred to the committee for action. The resolution directed KMA to produce an updated policy/guidelines statement on health system reform. The committee adopted a revised policy on health system reform which is attached to this report.

J. Michael Moore, MD, President of Fayette County Medical Society, addressed the committee regarding the situation in Fayette County whereby the county health department, due to budget shortfalls, no longer provides care to approximately 15,000 indigent patients. The situation was brought about by the shift to Medicaid Managed Care. Health departments relied upon Medicaid reimbursement to provide this service. Medicaid patients previously receiving care from the health department were assigned to private practitioners. Doctor Moore requested that the committee address this problem and provide some direction for the physicians of Fayette County who are unable to absorb the care of these patients. The committee referred the matter to the KMA Executive Committee.

After considerable discussion of KMA's position on expanding Medicaid, the committee recommended the following:

The Committee on State Legislative Activities recommends appropriate expansion of Medicaid to additional indigent patients provided the increased number of Medicaid eligible are properly funded by the Kentucky General Assembly.

Resolution 98-106, "Credentialing of Nuclear Medicine Technologists," states, "Resolved that the KMA endorse state credentialing of Nuclear Medicine Technologists by the Cabinet for Health Services." The House of Delegates opted not to adopt Resolution 98-106, but instead referred the resolution to the Board for further consideration. In Kentucky medical practitioners are "certified or licensed." The committee recommends that until KMA receives a formal request from the nuclear medicine technologists and reviews the actual proposal, the KMA refrain from commenting."

Resolution 98-124, "Physician Assistants," defines KMA's position on physician assistants as follows:



- Supports certification of PAs by the Board of Medical Licensure
- Supports reimbursement to physicians for services provided to their patients by supervised physician assistants
- Staff privileges should be determined by local institutions in conjunction with the medical staff
- Institution staff privileges should be based upon education, JCAHO standards, federal, state, and local laws.

The committee accepted Resolution 98-124 for informational purposes.

The fourth "Resolved" in Resolution 98-117, "Gag Clauses," was referred to the committee should further legislative action be indicated.

RESOLVED, that if a health plan argues that it does not have to abide by Kentucky State Law banning gag clauses because of ERISA or can be proven to have taken negative action against physicians for patient advocacy, the KMA consider regulatory, legislative, and legal action.

The committee accepted Resolution 98-117 for informational purposes.

Resolution 98-111, "Universal Access to Health Care" reaffirms KMA policy and was referred to the committee:

- Society has an obligation to make access to health care available to all of its citizens, regardless of ability to pay
- Supports a pluralistic approach to health care delivery systems and financing mechanisms in achieving universal health insurance coverage

The committee recommends the following amendment to Resolution 98-111:

Society has an obligation to make access to **necessary medical health** care available to all of its citizens, regardless of ability to pay

Resolution 98-119, "Insurance Department Enforcement of Late Payment Statutes," directs KMA to introduce legislation in the 2000 Session of the Kentucky General Assembly that:

- Requires insurers to notify physicians within 30 days if a claim is inadequately prepared, otherwise the claim is presumed valid.
- Requires third-party payers to pay electronically submitted claims within 15 days.
- Recommends the Department of Insurance track complaints on each payer and make the information available to physicians and the public.
- Explores legislative and legal means to apply the law to all payers including those exempted under ERISA.
- Urges authorities to strictly enforce the law.

The present law requires insurers to pay claims within 30 days from submission or pay 12% interest on the balance owed to the provider.

The committee directed staff to work with LRC on legislation that addresses the issues in Resolution 98-119 and report back to the committee.

Resolution 98-123, "Universal Vaccine," directs KMA to explore the feasibility of pursuing implementation of the Universal Vaccine Program in Kentucky. Harry W. Carlross, MD, President-Elect, researched the Universal Vaccine Program and discussed the proposal directly with Governor Paul Patton. If adopted, Kentucky would become the 16th state to allow physicians to purchase vaccine at the same price as health departments. Adoption will require biennial funding of approximately \$2 million from the General Assembly.

The 1998 KMA House of Delegates adopted a long-range strategic plan entitled "KMA Future Search." Portions of the strategic plans were referred to COSLA for implementation. The committee makes the following recommendations to implement portions of Future Search.

- (A) *Pursue legislative goals as directed by the House of Delegates, and develop and implement legislative strategies to achieve short- and long-term legislative priorities.*

THE COMMITTEE RECOMMENDS THE FOLLOWING STATE LEGISLATIVE SHORT- AND LONG-TERM PRIORITIES FOR CONSIDERATION:

1. Tort Reform

KMA supports an amendment to the Kentucky Constitution or federal legislation to limit the noneconomic component of medical liability awards. In addition, the KMA supports an amendment to the ERISA law to make managed care employees and physicians who make decisions that result in patient injury or death legally responsible for their decisions. The KMA recommends the establishment of arbitration boards to resolve problems without going to court, and limiting the level of contingency fees paid to

attorneys in medical malpractice awards. The KMA will oppose legislation that expands upon the nature and/or extent of recoveries allowable under the wrongful death law or other proposals that expand recovery in medical liability.

2. Patient Protection/Provider Fairness

Protection of the patient and quality care are paramount concerns of the Association. House Bill 315 addressed many of the relevant patient protection and provider fairness issues. The General Assembly should build on these reforms by making decision-makers employed or under contract to managed care plans accountable for determinations which result in injury or death to plan enrollees. Legislation providing independent, external appeals mechanisms for managed care plans should be enacted and provisions established to require insurers to pay physicians within 15 days for a clean, electronically submitted billing form. Continuity of care in the managed care environment, especially where terminally ill patients are involved, warrants special attention. Mechanisms should be established to assure that gravely ill patients are not cut off from physicians with whom they have established long-term relationships.

3. Public Health

The KMA should work with the Commissioner of Public Health and allied health organizations to improve the health and environment of the Commonwealth. The KMA discourages the use of tobacco among all Kentuckians and supports legislation to prevent children's access, purchase, and use of tobacco. Drug, alcohol, and domestic abuse preventative programs and treatments should be available. The KMA urges passage and stringent enforcement of traffic safety legislation, including requiring use of helmets by motorcyclists and bicyclists and prohibiting minors from riding in open vehicles on state highways, and stringent enforcement of driving under influence laws. The KMA supports mandatory health education (K-12) and sex education beginning in grades 5-7.

4. Medical Education and Research

Medical education and research is crucial to the future of this nation. The KMA supports Kentucky's medical schools, and recommends enhanced financing of medical education and research by Government and private resources. Insurance companies and managed care plans should adequately compensate medical schools for the additional costs of training medical students and residents.

5. Nonphysician Health Care Providers

The KMA is committed to an integrated system involving all health care professionals. Nonphysician practitioners should not serve as gatekeepers, perform surgery, or be granted authority to deny access to medical services. KMA should work to provide a forum for the resolution of conflicts that exist among professions on scope of practice issues. Enhancement of practice acts by "legislative fiat" undermines quality, increases cost, and should be opposed.

- (B) *Enhance and influence health care policy decisions in the governmental arena, through strengthened regulatory oversight, by monitoring and improving relationships with appropriate administrative and legislative agencies.*

COMMITTEE RECOMMENDATION:

The House of Delegates has strengthened legislative, regulatory, and administrative initiatives by increasing the budget in both the legislative arena and public education. Through additional staffing, COSLA has been able to effectively monitor interim legislative committees, address governmental regulatory and administrative proposals, and deal appropriately with other legislative activities. In addition, the House of Delegates has supported COSLA's efforts by budgeting funds and resources for legislative handbooks, reports, and weekly legislative bulletins to keep members informed and capable of working with locally elected officials.

- (C) *Reevaluate and develop legislative priorities and strategies on an annual basis, and provide for continual transition of KMA leadership and staff*

COMMITTEE RECOMMENDATION:

Reevaluating and developing legislative priorities and strategies is an ongoing process. Oversight by COSLA, Legislative Quick Action Committee, Board of Trustees, and the House of Delegates on an annual basis, provides continuity and makes KMA's legislative program and priorities accountable. The Legislative Quick Action Committee, which includes the Chair of COSLA, Vice Chair of COSLA, President, President-Elect, Chair of

the Board, and Secretary-Treasurer, meets weekly in Frankfort while the General Assembly is in Session with KMA lobbyists to develop strategy, establish priorities, and direct the overall lobbying effort. Communications is ongoing with appropriate specialty societies when legislation is introduced specific to their practice. The Board of Trustees has provided for continuity of the legislative leadership by appointing a Vice Chair of COSLA. In addition, the Executive Vice President has employed additional staff to begin an orderly internal transition in the Legislative Department.

Confidentiality of peer review continues to be an issue in the courts. The most recent Kentucky Supreme Court ruling once again held that peer review documents are discoverable. However, the Court strongly reaffirmed the immunity from damage claims by aggrieved physicians against those physicians who consult or participate in good faith peer review.

The committee continues its position that all peer review records should remain confidential and recommends that KMA continue study of the issue of confidentiality of peer review and consider legislation only when appropriate.

The issue of surgi-centers and other provisions of medical services owned and operated by physicians and statutory requirements to obtain a certificate of need remain topics of disagreement between KMA and the Kentucky Hospital Association. Staff reviewed the status of negotiations between KMA and KHA seeking to reach some agreement prior to the 2000 Session. The Committee on State Legislative Activities recommends that KMA retain its current position on Certificate of Need.

In 1994, the Cabinet for Health Services adopted regulations prohibiting Medicaid reimbursement for physician assistant services, basing its decision on the premise that PAs are certified, not licensed. Apparently, if PAs were "licensed," Medicaid would consider reimbursing PAs for their services. The 1998 KMA House of Delegates adopted Resolution 98-124 which directs that:

- KMA supports certification of PAs by the Board of Medical Licensure
- KMA supports reimbursement to physicians for services provided to their patients by supervised physician assistants.

The Committee on State Legislative Activities recommends that KMA retain its present position on reimbursement of nonphysician practitioners.

We are extremely pleased to welcome Marty White to the KMA staff and the legislative team. Marty comes to us with extensive experience in political action and association work. I want to personally thank the many KMA members and staff who have served on interim committees of the Kentucky General Assembly and who have given the views of the association regarding many items. Legislative efforts seem to have become a more year round activity. Don Chasteen is such an expert in keeping everything in perspective. Also, Bill Doll and John Cooper serve us well in Frankfort. As you see these individuals please say a big "thank you." On behalf of the entire "legislative team," we look forward to working with the members of KMA during the 2000 Kentucky General Assembly.

Wally O. Montgomery, MD
Chair

RECOMMENDATIONS:

1. The Committee on State Legislative Activities recommends appropriate expansion of Medicaid to additional indigent patients provided the increased number of Medicaid eligible are properly funded by the Kentucky General Assembly.
2. The Committee on State Legislative Activities recommends that until KMA receives a formal request to endorse credentialing from the nuclear medicine technologists and reviews the actual proposal, the KMA refrain from commenting.
3. The Committee on State Legislative Activities recommends the following amendment to Resolution 98-111: Society has an obligation to make access to **necessary medical health** care available to all of its citizens, regardless of ability to pay.
4. The Committee on State Legislative Activities continues its position that all peer review records should remain confidential and recommends that KMA continue study of the issue of confidentiality of peer review and consider legislation only when appropriate.
5. The Committee on State Legislative Activities recommends that KMA retain its current position on Certificate of Need.
6. The Committee on State Legislative Activities recommends that KMA retain its present position on reimbursement of nonphysician practitioners.

Health System Reform

(Addendum to the 1999 Report of the Committee on State Legislative Activities)

The 1998 KMA House of Delegates, through Resolution 98-112, directed the KMA Board of Trustees to "produce an updated Policy/Guidelines statement in 1999 on Health System Reform." The submitted resolution directed the Board to address 20 issues as outlined in the "Resolved" portions of the resolution. However, the House modified the directive as follows. "The Board shall consider, but not be limited to, the following issues in the Policy/Guideline statement. . ." The Board of Trustees referred Resolution 98-112 to the Committee on State Legislative Activities for study and development of a report to be presented to the 1999 House of Delegates. As the Committee on State Legislative Activities developed a position on reformation of the health system, we remained cognizant of the following:

- Individual positions on issues are linked with other recommendations, and must be considered within the entirety of the proposal. However, in the political arena, the risk is overwhelming that proposals will be taken out of context and enacted individually
- Sharply defined positions in the political environment may deprive physicians, particularly representatives of the body of medicine, from responding and participating in evolving initiatives when locked into specific positions
- Complicated and detailed positions can be difficult to comprehend and may be perceived negatively by members, legislators, and the public as causing more harm than good
- The crisis in the health care system is "cost," primarily due to technology, aging population, uninsured, and patient insulation from paying for services and products. Short of denying, delaying or rationing health care, neither government, employers, the public, nor physicians have found answers to this dilemma.

The federal ERISA law, which exempts self-insured plans from many state health insurance laws, is a major stumbling block for state efforts to reform the health system. It has been estimated that less than 30% of Kentuckians are affected by state health insurance laws. Individuals covered under self-insurance, Medicaid, Medicare, Workers Compensation, Kentucky Child Health Insurance Program and other government plans, along with the uninsured, are generally exempt from mandates and other state health insurance laws enacted by the General Assembly. Kentucky's experience, combined with several other states' ill-fated and disastrous experiments with "state-by-state" reform of the health care system, makes it less likely that extensive experimentation will be undertaken by individual states. While reluctant to leave anything as important as health care to the Federal Government; nonetheless, the United States health care system is so "institutionalized on a national basis" that AntiTrust laws, ERISA, and Interstate Commerce laws prevent effective reformation on a state level.

The major components of this report are drawn from and generally founded on AMA/KMA policy, reports, publications, and recommendations from Committee deliberations. The Committee has made an effort to address the 20 areas enumerated by the authors of Resolution 98-112. The House of Delegates and members of KMA are referred to the following AMA policies that may assist them in learning more about Health System Reform:

- Health Care Costs H-155 (pages 272-274)
- Health Care Delivery H-160 (pages 275-286)
- Health Care/System Reform (pages 287-311)
- Health Insurance (pages 318-322)
- Health Insurance: Benefits and Coverage (pages 322-325)
- Health Insurance: Claim Forms and Claims Processing (pages 325-329)
- Report of the Council on Medical Service CMS Report 9 -A-98
- House Bill 315 as enacted by the 1998 Kentucky General Assembly
- AMA's Comprehensive Summary of Patient Protection Laws in the States
- AMA's 1993 Health System Reform
- KMA Compendium on House of Delegates/ Board of Trustees Positions

The Committee on State Legislative Activities recommends a broad set of principles for health system reform based upon AMA's Health Commerce America. Where appropriate and applicable, the positions developed in this document apply equally to regular health insurance plans or managed care contacts and plans:



- Universal access to necessary medical care
- Freedom for patients to choose physicians and system of health care
- Quality assurance initiatives
- Reductions in administrative costs and relief from regulatory and administrative requirements
- Professional liability reform
- The right of physicians and physician organizations to negotiate with purchasers of managed care entities and third-party payers on clinical autonomy, quality and payment/ cost issues.
- Fair competition that enhances medical innovation. Strong opposition to imposed price controls, expenditure targets, or global budgets
- Adequate funding for federal and state health programs including Medicare, Medicaid, Child Health Insurance Programs, and Workers Compensation
- Health system reforms supportive of financing medical education and research
- Recognition of the physician's responsibility and authority in medical decision making and treatment in conjunction with the patient

Access to Insurance and Managed Care Plans

Insurance plans should provide telephone access for sufficient time during business and evening hours to ensure adequate access to routine health care services to enrollees. Insurance and managed care plans should make every effort to develop access plans for the needs of enrollees from underserved populations.

Access to Specialty Care and Referral

Insurance and managed care plans should be required to demonstrate that there are adequate physicians for enrollees to have an appropriate choice of physicians and access to services. Each insurance or managed care plan should develop appropriate plans to ensure proper access to specialty care including: referral to a nonparticipating specialist in instances where the network does not have a specialist in the appropriate area; the provision of standing referrals to a particular specialist in necessary instances; the coordination of care by a specialist for enrollees with life-threatening or degenerative/disabling conditions and/or referral to a specialty care center if care would be most appropriately provided.

Allied Health Professionals

Physician assistants, Advanced Registered Nurse Practitioners, and pharmacists should be able to provide professional services under their scope of practice so long as the services provided are pursuant to protocols by a medical doctor with whom the patient has established a physician-patient relationship. Plans should not be required to reimburse nonphysician practitioners directly.

Anti-Trust Relief

If physicians are to be successful advocates for patients to ensure high quality and affordable insurance, Congress, the Department of Justice, and the Federal Trade Commission must enact federal legislation and appropriate regulations to permit physicians to negotiate with health insurance plans without fear of anti-trust implications. Anti-trust relief should be designed to facilitate physician negotiation with managed care plans and require managed care plans to allow participating physicians to organize for the purpose of commenting on the medical review criteria. That review should include the development of information and networks of consultants necessary to assist physicians in their interaction with managed care plans.

Any Willing Provider

Health care benefit plans should not discriminate against any provider, located within the geographic coverage area of the health benefit plan, willing to meet the terms and conditions for participation established by the health benefit plan.

Availability

Every insurer should be required to offer a "basic" plan, on a guaranteed-issue basis, as a condition of doing business in Kentucky.

Certificate of Authority

Managed care organizations must obtain a certificate of authority to operate managed care plans. The application should include complaint processes; terms and conditions; compensation arrangements including financial incentives to physicians; documentation demonstrating that the plan will

pay for emergency services performed by nonnetwork physicians; description of the geographic location covered by the plan; and financial statements, bylaws, rules and appropriate information as required by the Commissioner of Insurance.

Choice of Physicians

Enrollees must have adequate choice among accessible and qualified participating primary care physicians. Patients should be permitted to choose their primary care physician from a list of current physicians and the list must be updated as physicians are added or removed from the plan. Women should be permitted to choose a qualified physician for routine and preventative women's medical services. Access to a consultation with participating physicians for second opinions should be available.

Claim Filings/Standard Claim Form/Electronic Claim Submission

KMA supports a standard, mandatory, and common claim form for all insurers. Insurance companies should be required to adopt a standardized or open electronic claims submission protocol. Physicians should be provided incentives to switch to a uniform electronic billing in a uniform format within a designated period of time. Physicians' should not be penalized for failure to adopt electronic billing systems.

Coding

The KMA supports statewide use of AMA CPT coding by insurance carriers.

Collective Negotiating

The KMA supports legislation that would empower individual self-employed physicians to engage in joint negotiations with health plans.

Confidentiality

Health insurers must protect patients' rights of privacy regarding medical records and communications between patients and physicians. Clear and definitive action should be taken by the insurer during enrollment to inform the insured that under specific circumstances, especially when seeking approval for a service or billing for reimbursement, transfer of the patient's medical record information will take place between the physician and insurer. No third party to whom disclosure of patient records is made may redisclose or otherwise reveal the mental health and chemical dependency records of a patient without first obtaining the patient's specific written consent to the redisclosure. Procedures should be established to safeguard the privacy of individually identifiable patient information and to maintain accurate and timely records for patients.

Consumer Assistance Program

Insurance and managed care plans should establish a Consumer Assistance Office to respond to consumer questions and concerns, assist patients in exercising their rights, and protect their interests. The establishment of a Consumer Advisory Board is appropriate to advise the insurer. The Commissioner of Insurance should establish and staff a managed care Ombudsman Office to assist patients and protect their interests. Appropriate complaint procedures should be established and enforced.

Consumer Disclosure

In order that consumers may make informed choices, health insurers must disclose in written, easily understood format the following: terms and conditions of contracts to enrollees including covered services and benefits; restriction and limitations on covered services; financial responsibility of the covered person including copayments and deductibles; prior authorization requirements; where and what manner covered services may be obtained; changes in services or benefits; and measures in place to ensure confidentiality of the relationship between the enrollee and the physician and how to initiate an appeal of a utilization management decision. Insurers that offer managed care plans must disclose a current participating physician directory; financial incentives with participating physicians; customary waiting times for appointments for urgent and routine care; information on provider network including hospital affiliations; physician board certifications and physicians' acceptability of new patients.

Consumption of Benefits

Rising medical costs require patients and physicians to use appropriate restraint in utilizing health insurance. Healthy lifestyles, preventive health measures, and proper restraint in the use of drugs, alcohol, and tobacco can

dramatically restrain health costs. Patients have an individual responsibility to be aware of the benefits and limitations of their health care coverage. Patients should exercise autonomy by participation in the formulation of benefit packages and by prudent selection of health care coverage that best suits their needs. The US Congress and the Kentucky General Assembly should actively promote health and medical education in schools and to the public. In addition, the KMA supports Medical Savings Accounts, various deductible type insurance plans, and other insurance incentive plans as alternatives to contemporary health insurance and managed care policies. The KMA opposes any financial incentives that directly compensate physicians for ordering or providing less medically necessary or appropriate medical care.

Continuity of Care

Carriers should maintain a plan for providing continuity of care in the event of contract termination with the participating physician or in the event of insolvency or other inability to continue operations. Insurance and managed care plans must provide coverage for enrollees undergoing a course of treatment with a participating physician who has been terminated. That treatment should be covered for the remainder of the course of treatment or for 90 days after termination of the contract.

Contractual Agreements between Physicians and Insurers

The KMA endorses a "Standard Physician Service Agreement" that can be used statewide on a voluntary basis by Kentucky physicians in their contractual arrangements with third-party payers. The agreement should set forth rights and obligations of the physician and payer in a consistent and uniform fashion. The agreement should include standard provisions for licensure and certification; liability insurance coverage; maintenance of and access to records; credentialing and profiling information; provisions for termination and dispute resolution. Fees should not be set. The contract should refer to a blank fee schedule of CPT codes to be negotiated by each individual physician.

Coverage Limitations

Any insurer who limits coverage or treatment must define the limitation and disclose the limits. Insurers should note and disclose who is authorized to make determination and the criteria the plan uses to determine whether a treatment, procedure, drug or device is covered. Once a health plan receives a request for prior authorization of a procedure, and required information is received, the insurer should issue a coverage decision. The plan must provide a letter of denial setting forth the specific medical and scientific reasons for denying coverage and notice of the insured's right to appeal and a description of the appeal process.

Data Collection

Insurers, including ERISA-exempt plan contractors, should be required to provide health insurance data as identified by the Commissioner of Insurance. Data may include total premiums, enrollment statistics, costs, claims paid and policies cancelled. Physician data is submitted routinely to carriers on a claim-by-claim basis and reports related to patients can be easily obtained from claims submitted.

Emergency Care

Health plans should educate their insured about the use of emergency services, and availability of other more appropriate medical services. Plans must cover emergency department screening and stabilization without prior authorization for use consistent with the "prudent layperson" standard.

Equality and Fairness in Delivery of Medical Care

Disparities in the delivery and rendering of medical care, whether based upon race, gender, income, education, social, cultural or geographic factors, are unjustifiable and must be eliminated. Physicians should examine their practices to ensure that prejudices and biases do not inadvertently affect clinical judgement in medical care. The KMA supports the position that resources for medical research should be distributed in a manner which promotes the health of all individuals without regard to race, sex, or gender to the greatest extent possible.

Experimental Treatment

Clinical research is important to the development of more effective and often more cost-effective treatments. Patients should have access to, when appropriate, and be encouraged to participate in clinical trials. Physicians, not

insurers, should determine whether various treatments are consistent with the standard of care or considered experimental. Insurers should provide coverage for patient care in the context of clinical trials which do not increase significantly the cost of care. Plans that limit coverage of experimental treatment must define the limitation and disclose the limits. Plans should note and disclose who is authorized to make determination and the criteria the plan uses to determine whether a treatment, procedure, drug or device is experimental. Once a health plan receives a request for prior authorization of an experimental procedure, and required information is received, the plan should issue a coverage decision within five working days. If the insured is diagnosed as terminal, the plan must provide a letter of denial setting forth the specific medical and scientific reasons for denying coverage and notice of the insured's right to appeal and a description of the appeal process.

External Appeals

Independent external appeals programs should be established to provide an independent medical necessity or appropriateness of service review of final decisions by insurers to deny, reduce, or terminate benefits. Appeals should be determined by physicians practicing in the same state as the insured who is appealing. Physicians involved in the review process should be independent of the carrier. Physicians, who act without malice or fraud, and within the scope and function of the review process, should be immune from liability for decisions rendered. The cost of external appeals should be borne by the carriers.

Financial Incentives

Insurers and managed care organizations may not use financial incentives that directly compensate physicians for ordering or providing less medically necessary or appropriate health care.

Financing Health System Reform

Solutions to the development of programs to insure Americans should be within the private sector as much as possible. The Federal Employee Health Benefit Program (FEHBP), the only existing national managed competition program, offers a real-life model. The FEHBP provides a set contribution toward the monthly premium and then permits employees to choose from various health plans. There are a variety of approaches to Universal Coverage and financing, including employer mandate, individual mandate, or Medical Savings Accounts. Tax policies should be consistent and fair for both group and individual purchasers, and incentives for individuals to purchase health insurance should be considered. There are several options for expanding Medicaid and Medicare under consideration at present, and programs similar to Kentucky's Guaranteed Acceptance Program for the uninsurable should be in place in each state. KMA opposes any funding plan that singles out physicians as a discrete element within society and places upon physicians a unique and disproportionate responsibility for the funding of health care. KMA supports expansion of Medicaid to cover additional indigent individuals provided adequate long-term funding is appropriated.

Gag Clauses

Insurance and managed care plans may not contract with a physician to limit the physician's disclosure to an enrollee of any information relating to the patient's medical condition or treatment option. Physicians shall not be penalized, nor have contracts terminated, for discussing medically necessary or appropriate care with enrollees. Physicians may discuss all treatment options, and discuss financial arrangements between the physician and the insurer with an enrollee.

Genetic Testing

An insurer should be prohibited from denying, canceling, refusing to renew, or varying terms and premiums based upon results of genetic testing.

Grievance and Appeal Procedures

Any insured denied a covered service or whose claim for services is denied may pursue an established review process. Each insurer must include with the insured's policy evidence of coverage and a separate information packet regarding their appeal process. Several review mechanisms should be included in an appropriate grievance and appeal process. An Expedited Review process should be available when an insured has been denied a covered service. When this occurs, the treating physician must certify in writing and provide supporting documentation to the utilization review agent that the time period for a lengthy reconsideration could cause



significant negative change in the insured's medical condition. Under the Expedited Review process, the review agent must respond in one working day by mail to the insured and the treating physician.

A final Independent External Review process should be available for patients denied a medical service or for cases involving an issue of coverage. The External Independent Review Committee should be composed of physicians practicing in the same specialty and preferably in the same state as the treating physician and the insured. Procedural guidelines should be established for cases involving medical necessity and issue of coverage, and information relating to these guidelines should be made available to both the patient and physician. The physician reviewers should be independent of the carrier, the treating physician, and the patient.

Internal appeal processes and informal reconsideration for denial of claims or services for elective, non-emergency, or routine conditions should also be made available to the insured and the treating physician.

Health Promotion/Disease and Violence Prevention

Physicians and patients should become more active participants in health promotion and disease and violence prevention. Physicians should play an active part in emphasizing healthy lifestyles. Such activities can improve the extent and quality of life and reduce health spending. Physicians, health insurance companies, and private and government agencies should encourage health promotion and disease prevention measures. Programs include: smoking cessation, treatment/prevention of alcohol and drug abuse, appropriate and healthy diet, adolescent health measures, enforcement of traffic and boating safety laws, regular exercise programs; recognizing and reporting family violence; cancer screening; and other appropriate measures. Health insurance companies should encourage health promotion and disease prevention by reducing premiums for enrollees who exhibit healthy lifestyles.

High-Risk Individuals

The KMA supports state-operated plans that provide health insurance to high-risk individuals under private or group policies. Insurance companies which market in this state should either participate in the insuring of high-risk individuals or assist in the funding of such plans. The Insurance Commissioner should define those conditions classified as "high risk" in consultation with appropriate medical and insurance professionals.

Information Systems to Judge Quality and Cost-Effectiveness

Quality is defined by the AMA Council on Medical Service as the degree to which care services influence the probability of optimal patient outcomes. Adequate levels of government and private funding should be budgeted to finance outcomes research, practice parameters development, and similar approaches, provided they have appropriate physician input. The results of such mechanisms should be educational and not punitive. Third-party payers should be prohibited from releasing information except to the individual physician or within a formal peer review process.

Long-Term Care Insurance

The purchase of long-term care (LTC) insurance with the ability to deduct the LTC premiums from taxes is supported by the KMA.

Managed Care Protection

Protections should be enacted to monitor managed care and assure patient safety and decreased costs, along with quality care. Protections should include patient rights, physician fairness standards, and physician advocacy for patients to enhance patient safety and quality of care.

Managed Care Liability

Patients who suffer injury or death resulting from a decision to delay or deny care by a managed care plan employee or plan medical director should be permitted to bring action against the plan to recover damages.

Medical Necessity

The KMA supports the position that only physicians may determine medical necessity. Medical necessity is clearly defined as health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms:

- (1) In accordance with generally accepted standards of medical practice
- (2) Clinically appropriate in terms of type, frequency, extent, site and duration
- (3) Not primarily for the convenience of the patient, physician, or other health care provider

Medical Review Committee

A medical review committee is composed of physicians under the auspices or requirements of medical associations or societies, hospitals, clinics, nursing homes, private insurers, government, or other entities which require or generate review of medical care. A medical review committee evaluates the quality, cost, and necessity of medical services, including credentialing. Members who act without malice or fraud should not be subject to liability for damages on account of any act, statement, or proceeding performed within the scope and functions of the committee. Proceedings of the medical review committee, records and the materials it produces, and materials it reviews should be confidential and not considered public records.

Medical/Physical/Mental Illness Parity

The KMA supports the provision of benefits for emotional and mental illness, which are equivalent in scope and duration to those benefits provided for other medical or physical illnesses, under all government and private insurance programs.

Medical Savings Accounts

The KMA supports Medical Savings Accounts as another individual option in the health insurance market.

Most Favored Nation Clause

KMA opposes the insertion of "most favored nation" (MFN) clauses in contracts between physicians and health insurance plans or managed care organizations. MFNs require physicians to afford the insurance or managed care organization the same rates provided to other payers if such rates are more favorable. MFNs require physicians to charge the insurer or managed care organization the lowest rate paid to the physician by other health plans.

Network Adequacy

Managed care plans must have sufficient number and type of primary care physicians, specialists and subspecialists throughout the plan area. The network should be available to enrollees within 30 miles or 30 minutes, and access to urgent and emergency care should be well defined. Telephone access to the plan during business hours should be available, and reasonable standards for waiting times to obtain appointments should be present.

Out of Network Care

When coverage from the insurer or managed care plan is not possible, the primary care physician and insurer must refer the patient to an appropriate out-of-network physician within a reasonable time and proximity to the enrollee's home. The out-of-network physician should be reimbursed either the UCR fee or the agreed upon fee between the insurer and the out-of-network physician.

Patient Rights

Patients should receive in writing, in understandable format, the following:

- Services covered or excluded printed in easily understood language
- Preauthorization requirements for services which if not obtained may lead to denial of coverage
- Physician/ Insurer financial arrangements which may limit or restrict services
- Contract language in understandable format
- Ability to continue treatment with physician of choice during period of enrollment, or period of treatment
- Right to receive emergency care regardless of physician, site or location based upon the "prudent layperson" standard
- Establishment of an external review procedure or grievance mechanism to provide an appeal process to resolve disputes

Physician Credentialing

Insurance and managed care plans must establish minimal professional requirements for participating physicians. Plans must have a process for the selection of physicians, with written policies, procedures, and approvals used by the plan. The selection process should include verification of each health care physician's license, history of license suspension or revocation, and liability claims history.

Physician Fairness

- Physicians should be permitted to negotiate with managed care as appropriate.

- Plans should encourage formal physician input into the development and refinement of medical policies including credentialing, utilization review, quality assurance and benefit package.
- Plans should disclose all participation requirements and selective contracting decisions, and reasons for physician denial or de-selection. A physician de-selection process should be included in the contractual agreements defining notification procedures and reasons for de-selection.
- Plans should provide enrollees and participating physicians with the opportunity to complete a "report card" at regular intervals regarding quality of service.
- There should be no payment differentials to physicians based on geographic location. Reimbursement methodologies should not discriminate against any class or specialty of physicians. In the process of instituting single, equitable statewide reimbursement schedules, insurance companies should not diminish existing reimbursement schedules.
- Gag or "hold harmless" clauses in contracts between managed care entities and physicians are unethical and should be banned.
- In accordance with the principles of medical ethics, except in emergencies, physicians are free to choose whom to serve, with whom to associate, and the environment in which to provide medical service.

Physician Responsibility for Patient Advocacy

- The duty of patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the system of health care delivery in which physicians practice. Physicians must continue to place the interests of their patients first
- Physicians must advocate for appropriate care they believe will materially benefit their patients
- Physicians should be given an active role in contributing their expertise to any allocation process and should advocate guidelines that are sensitive to differences among patients
- Strong appellate mechanisms, including independent external appeals processes, for both patients and physicians, should be in place to address disputes regarding medically necessary care
- Health insurance and managed care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information, including limitations or restrictions on benefits before entering a plan
- Physicians should not participate in any plan that encourages or requires care at or below minimal professional standards
- Financial incentives are permissible only if they promote cost-effective delivery of health care and not withholding of necessary medical care

Pharmaceutical Utilization Review

See Coverage Limitations

Plan Certification

The Commissioner of Insurance should promulgate rules to certify managed care plans and utilization reviews programs, and identify procedures for periodic review and recertification.

Point-of-Service

A point-of-service option should be required in all non-ERISA managed health care plans. Insurers should offer a benefit plan with a point-of-service option to obtain out-of-network benefits without having to obtain a referral. Plans may require enrollees to precertify selected services, pay a higher deductible, co-payment, or higher premium. Insurers should provide each enrollee the opportunity to enroll in an out of network option, and provide written notice of out of network benefits and financial costs.

Portability

Once an individual obtains health insurance, they may use evidence of that insurance to reduce or eliminate any preexisting medical condition exclusion period imposed upon them by joining another group plan or transferring to an individual policy. Portability is defined simply as maintaining coverage and giving credit for having been insured when changing health plans.

Preexisting Conditions

When an individual applies during open enrollment in a health plan, health insurance policies or contracts relating to preexisting conditions on diseases or health conditions should not extend beyond 9 months for maternity benefits and 12 months for all other conditions.

Prompt Payment

Managed care plans or licensed insurers must pay a written claim submitted by physicians within 30 days of receipt of fully documented clean claim. Payers should be required to notify physicians within 30 days if a claim is inadequately prepared. Otherwise the claim is presumed valid. Payments for electronically filed claims should be paid within 15 days. If plans fail to remit payment as required, interest may accrue at 12% per annum added to the amount owed on the fully documented clean claim. The KMA recommends that the Department of Insurance (DOI) adopt regulations that define a "clean claim." The law should apply to all third-party payers, including those under the federal ERISA law, and the statutes should be rigidly enforced.

Provider-Sponsored Networks

KMA supports Provider-Sponsored Network (PSN) provisions, and the lesser requirements of PSNs to maintain reserve levels. Provider-sponsored integrated health delivery network means an organization wholly owned, governed, and managed by health care providers, and which provides through arrangements with others, a health benefit plan to consumers voluntarily enrolled in the organization on a per capita or a predetermined, fixed prepayment basis. PSNs' authority allows providers to assume risk for coverage but does not require them to fund and maintain the reserve levels required of insurers.

Quality Assurance and Improvement Standards

Health plans must develop comprehensive quality assurance or improvement standards. These standards should be adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of health care services.

Quality of Patient Care

AMA defines quality of care as "the degree to which care services influence the probability of optimal patient outcomes." Physicians are uniquely qualified and positioned to provide quality measurement. The present managed care and health insurance market is driven by cost and there is the potential for price competition that may negatively affect quality care in very significant ways. Physicians must reclaim their role in determining the clinical configuration of the emerging managed care and health insurance system. Through various organizations, including IPAS, large practices, physician management enterprises, medical societies, and other ventures with hospitals and providers, physicians now have the ability and opportunity to evaluate the content of care. The KMA believes that physicians and patients must be aggressive in retaining their rightful place in the emerging delivery system. The medical association, legislative bodies, and patient consumer groups must position physicians to serve the legislative purpose of our medical care system—assuring appropriate access to quality care.

Regulation

The burden of government and third-party regulation on medical practice and health insurance should be reduced. Its intrusion and "hassle factor" into the physician-patient relationship and doctor-patient time is costly and delays treatment of patients. The Association vigorously opposes uncompensated regulatory requirements for physicians and supports economic impact statement requirements for all legislation and regulation affecting the delivery of medical care and increased cost.

Renewability

Health plans should be required to renew contracts except for nonpayment of premium, fraud, misrepresentation, noncompliance with plan provisions, or if the insurer ceases doing business in Kentucky.

Screening

Screening should be defined in managed care and insurance contracts as health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition.

State Patient Protections vs Federal Patient Rights Bills

Federal patient protection enactments should become a floor and not a ceiling for state managed care fairness reforms.

Tax Subsidization of Insurance Spending

The KMA recognizes federal and state tax inequities governing health



insurance, and supports tax policies that are equally fair to employer, employee, self-insured, and nongroup private purchasers.

Tort Reform

KMA supports an amendment to the Kentucky Constitution or the adoption of federal legislation that limits noneconomic damages. KMA supports an amendment to the federal ERISA law that immunizes employer-sponsored health plans from state-based liability claims by injured patients. Patients covered by ERISA plans should have the same right of redress as those who are covered by non-ERISA plans. Permitting plans to escape liability for negligence due to legal loopholes places patients in serious jeopardy. Health insurance and managed care employees and physicians who make decisions that result in patient injury or death should be held legally responsible for their decisions. Other supported measures include establishment of arbitration boards to resolve problems without going to court, and limiting the percentage lawyers can take of an award.

Treatment of Uninsured/Indigent

In accordance with ethical principles, each physician has an obligation to share in providing care to the indigent. The KMA supports the establishment of free medical clinics and programs to treat the poor. Several county medical societies are operating free clinics and other indigent care programs. The KMA has been recognized nationally for founding the Kentucky Physician Care program, which was established in 1985. Over 2000 Kentucky physicians participate in this model program to treat uninsured patients, which has treated approximately 200,000 patients without charge.

Uninsured

KMA recommends risk pools and voluntary programs to provide insurance for the uninsured indigent. Specific incentives to employers who provide group health insurance should be advocated, and enactment of tax and employment practices that encourage employers to include dependents is supported. The KMA supports the Child Health Insurance Program (KCHIP) and Medicaid expansion provided it is appropriately funded to provide health insurance for Kentucky children.

Universal Access to Necessary Medical Care

Society has an obligation to provide access to necessary medical care for all of its citizens, regardless of ability to pay.

Universal Health Insurance Coverage

KMA affirms its support for a pluralistic approach to health care delivery systems and financing mechanisms in achieving universal health insurance coverage. We recommend a plan that provides a standard set of benefits and includes a fee-for-service option. There are a variety of approaches to Universal Coverage, including employer mandate, individual mandate, or Medical Savings Accounts. The KMA strongly supports the patient's freedom and responsibility to choose his/her physician, insurance carrier, and health insurance. Nationalized or socialized health care plans, or single payer systems are not in the best interest of the patient, physician, or the nation and should be opposed.

Unnecessary Clerical and Documentation Requirements

KMA opposes clerical and related requirements imposed by insurance or managed care entities that are disruptive to the physician-patient relationship, jeopardize quality of care, and result in cost shifting, rather than long-term cost savings. Physicians spend an inordinate amount of patient care time documenting records to comply with reimbursement, fraud and abuse, and professional liability requirements. Government, health insurers, and other entities should be required to provide economic impact statement requirements for all legislation, regulation, and imposition of clerical and documentation requirements upon providers of medical care.

Further, insurers requiring preauthorizations, precertifications, referrals, or other tools for directing or managing a patient's care, must provide these services through a centralized mechanism which is easily accessible by network providers (ie, no lengthy telephone delays, additional paperwork outside the original medical record, etc).

Utilization Review

Utilization Review (UR) programs should be based on open and consistent review criteria that are acceptable to, and have been developed in conjunction with, the medical profession. Physicians participating in the UR process should be actively practicing physicians in direct patient care, in the same

specialty as that of the physician or service under review. Physicians reviewing medical necessity, appropriateness of services, or site of services should be licensed in Kentucky.

RECOMMENDATIONS, REFERENCE COMMITTEE C:

Reference Committee C next reviewed the Report of the Committee on State Legislative Activities and its Recommendations.

Reference Committee C recommends that Report No. 21 and its Recommendations be adopted.

RESOLUTION 99-103

Repeal of Stark Law Board of Trustees

WHEREAS, the so-called federal "Stark Laws" were passed in the early 1990s in order to limit a physician's ability to refer patients to a facility in which the physician or the physician's family member has a financial interest; and

WHEREAS, the federal government has, since the passage of the Stark Laws, drafted numerous regulations further limiting what physicians may not do in the area of referrals; and

WHEREAS, rapid consolidation within the health care industry is taking place among physician practices, hospitals and other entities; and

WHEREAS, physicians involved in such consolidated arrangements accept substantial financial risk for providing services, thus eliminating incentives for overutilization or inappropriate referrals; and

WHEREAS, the Stark laws and regulations have a significant impact on how physicians deliver health care services and the manner in which physicians relate to one another and to the other organizations within the health care community; and

WHEREAS, legal experts working full time on interpreting these provisions cannot reach agreement on what they mean; and

WHEREAS, physicians, whose job it is to treat sick people and prevent illness, are expected to understand all of these extremely complex rules or face devastating penalties; and

WHEREAS, a congressional committee took note of the confusion in this law and expressed frustration with HCFA in its drafting and implementation of regulations; now, therefore, be it

RESOLVED, that KMA support repeal of the Stark Laws; and be it further

RESOLVED, that KMA ask Kentucky's Congressional Delegation to support repeal of the Stark Laws because of their confusion and unneeded limitations; and be it further

RESOLVED, that the KMA support activities of the American Medical Association to repeal the Stark Laws.

RECOMMENDATIONS, REFERENCE COMMITTEE C:

Reference Committee C considered Resolution 103, Repeal of Stark Law, submitted by the Board of Trustees. Reference Committee C recommends Resolution 103 be adopted.

RESOLUTION 99-105

Determination of Medical Necessity Board of Trustees

WHEREAS, Health Maintenance Organizations (HMOs) and other insurance carriers have inappropriately assumed the determination of medical necessity; and

WHEREAS, many medical necessity decisions made by HMOs affecting patient care contradict the medical judgement of the attending physician; and

WHEREAS, decisions of medical necessity made by HMOs have sometimes resulted in delays or inadequate care for the patient; and

WHEREAS, many medical necessity decisions made by HMOs have resulted in lawsuits thereby driving up the cost of health insurance premiums; and

WHEREAS, the Kentucky Medical Association, American Medical Association and several other physician groups have policies stating that the determination of medical necessity should remain with practicing physicians and not insurance companies; now, therefore, be it

RESOLVED, that the Kentucky Medical Association support legislation, regulations, and agency and institutional policies that demand that patients' practicing physicians determine what is or is not medically necessary and in the best interest of their care and overall health; and be it further

RESOLVED, that the legislation, regulations, and agency and institutional policies endorsed by the Kentucky Medical Association include the following definition of medical necessity: Health care services or products a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site and duration; (3) not primarily for the convenience of the patient, physician or other health care provider. Patients should not be treated unfairly by health plans or insurers, by denying coverage for medically necessary treatment, based on information the plan or insurer obtains only later in the course of treatment. Medical necessity should be determined according to a "prudent physician standard," which legally and medically is an objective standard.

RECOMMENDATIONS, REFERENCE COMMITTEE C:

Reference Committee C next considered Resolution 105, Determination of Medical Necessity, submitted by the Board of Trustees. Reference Committee C recommends Resolution 105 be adopted.

RESOLUTION 99-113

Repeal Free Medical Record Mandate Jefferson County Medical Society

WHEREAS, HB 250 established the requirement that upon a patient's written request, physicians shall provide, without charge to the patient, a copy of the patient's medical record; and

WHEREAS, permitting providers to charge reasonable fees to provide copies of medical records has been a secondary legislative goal of the KMA ever since the mandate's codification as KRS 422.317(l); and

WHEREAS, the KMA has made repeated and frequent efforts to repeal the free medical records provision; and

WHEREAS, the free medical record law is extremely popular with the public, consumer groups, legislators, lawyers, and in particular, the trial bar; and

WHEREAS, KMA successfully defeated an attempt by the Kentucky Association of Trial Lawyers to require that medical records be reproduced on "copyable" paper; now, therefore, be it

RESOLVED, that the Kentucky Medical Association Committee on State Legislative Activities and the KMA Quick Action Committee continue to give repeal of Kentucky's free medical records requirement in KRS 422.317(l) the highest appropriate priority in the context of the political working environment of the Kentucky General Assembly and other KMA legislative priorities; and be it further

RESOLVED, that the KMA continue to keep its members informed of these efforts and of opportunities for grassroots legislative effort to give physicians the right to charge a reasonable fee for providing a copy of a patient's medical record.

RECOMMENDATIONS, REFERENCE COMMITTEE C:

Reference Committee C next considered Resolution 113, Repeal Free Medical Record Mandate, submitted by the Jefferson County Medical Society, and recommends amendment of the first Resolved as follows:

RESOLVED, that the Kentucky Medical Association Committee on State Legislative Activities and the KMA Quick Action Committee continue to ~~seek~~ **give** repeal of Kentucky's free medical records requirement in KRS 422.317(l) ~~the highest appropriate priority in the context of the political working environment of the Kentucky General Assembly and other KMA legislative priorities; and be it further~~

Reference Committee C felt that this is indeed a topic that all physicians feel is important. However, even though this is a topic of concern, it would not be politically expedient for the KMA to place this as a high priority in its legislative efforts.

Reference Committee C recommends adoption of Resolution 113 as amended.

RESOLUTION 99-115

Anti-Trust Relief

Jefferson County Medical Society

WHEREAS, no business person would operate his/her business under the terms of such contracts as the ones physicians sign with insurance companies; and

WHEREAS, individuals or small groups of physicians have no negotiating clout with insurance companies; and

WHEREAS, for ethical and moral reasons related to a sense of obligation toward patients, it is very difficult for physicians to drop out of insurance plans; now, therefore, be it

RESOLVED, that the Kentucky Medical Association make it a priority to obtain anti-trust relief that enables independent physicians to negotiate collectively with insurance companies (using the Texas model, if appropriate).

RECOMMENDATIONS, REFERENCE COMMITTEE C:

Reference Committee C next considered Resolution 115, Anti-trust Relief, submitted by the Jefferson County Medical Society, and recommends the Resolution be amended as follows:

RESOLVED, that the Kentucky Medical Association make it **the high-**est priority to obtain anti-trust relief that enables independent physicians to negotiate collectively with insurance companies ~~(using the Texas model, if appropriate).~~

Reference Committee C recommends adoption of Resolution 115 as amended.

RESOLUTION 99-116

Out-of-Network Benefits

Jefferson County Medical Society

WHEREAS, patients have been shown to value the ability to select their own physicians, and the current insurance situation is interfering with the doctor-patient relationship; and

WHEREAS, patients are often willing to pay physicians' charges out-of-pocket but are unable to pay for hospital services, laboratory and radiologic testing, in addition to their own premiums; and

WHEREAS, egregious contract terms are forcing many physicians to drop out or participate with decreasing numbers of insurance plans; and

WHEREAS, if a "participating" physician hospitalized the patient or ordered the exact same tests, they would be covered; now, therefore, be it

RESOLVED, that the Kentucky Medical Association make as a priority legislation requiring all insurance companies to provide out-of-network benefits to their insureds.

RESOLUTION 99-132

Out-of-Network Benefits

KMA Board of Trustees

WHEREAS, patients have been shown to value the ability to select their own physicians, and the current insurance situation is interfering with the doctor-patient relationship; and

WHEREAS, patients are often willing to pay physicians' charges out-of-pocket but are unable to pay for hospital services, laboratory and radiologic testing, in addition to their own premiums; and

WHEREAS, egregious contract terms are forcing many physicians to drop out or participate with decreasing numbers of insurance plans; and

WHEREAS, indicated tests and procedures ordered by a participating physician would be reimbursed and indicated tests and procedures ordered by a nonparticipating physician may not; now, therefore, be it

RESOLVED, that the Kentucky Medical Association reaffirms its support for the requirement that all payors provide products containing out-of-network, point-of-service benefits to their insureds; and, be it further

RESOLVED, the Kentucky Medical Association supports appropriate reimbursement for procedures ordered by nonparticipating physicians when medically appropriate.

RECOMMENDATIONS, REFERENCE COMMITTEE C:

Reference Committee C next considered Resolution 116, Out-of-Network Benefits, submitted by the Jefferson County Medical Society, and Resolution 132, Out-of-Network Benefits, submitted by the Board of Trustees.



Reference Committee C recommends that the final Resolved of Resolution 132 be amended as follows:

RESOLVED, that the Kentucky Medical Association supports a requirement that reimbursement to participating hospitals, laboratories and ancillary service providers should be the same whether or not the ordering physician participates in the patient's plan appropriate reimbursement for procedures ordered by nonparticipating physicians when medically appropriate.

Reference Committee C recommends the amended version of Resolution 132 be adopted in lieu of Resolution 116.

After considerable discussion, action from the floor of the House was to adopt the 1st Resolved of Resolution 132 in lieu of Resolution 116, and refer the 2nd Resolved to the Board of Trustees.

RESOLUTION 99-128

State Action Doctrine Board of Trustees

WHEREAS, the KMA Committee to Investigate Changing Trends in Medicine, in response to Resolution 98-104, developed an extensive report to the 1999 KMA House of Delegates on the antitrust environment relating to medical practice; and

WHEREAS, federal and state laws have granted health plans unprecedented control over patient care and created a severe imbalance between patient care, physicians and health plans; and

WHEREAS, patients' access to medical care and physicians' ability to determine treatment or medical necessity has been seriously impaired by HMOs and managed care decisions that have caused documented injury and death to patients; and

WHEREAS, the 1999 AMA House of Delegates adopted Substitute Resolution 901 supporting the development and operation of local negotiating units as an option for employed physicians; and

WHEREAS, two states have recently adopted legislation based on a United State Supreme Court ruling that set forth the concept known as the "State Action Doctrine" which states that federal antitrust laws do not apply to action by a state, or to private conduct compelled or approved by the state which allows behavior that would otherwise violate federal antitrust laws; and

WHEREAS, physician collective bargaining conducted under the auspices of the "State Action Doctrine" must be subject to "active state supervision" which would require state government to exercise an unknown degree of independent judgment or control over the entire bargaining process; and

WHEREAS, while the "State Action Doctrine" concept appears to hold some potential for allowing physicians to negotiate with payers, it is largely untested in physician/payer negotiations; and

WHEREAS, the AMA and KMA are in strong support of HR 1304, introduced by Representative Tom Campbell of California, which proposes to modify federal antitrust laws to permit individual physicians to engage in joint negotiations with health plans; and

WHEREAS, the concept of collective negotiating or bargaining has negative connotations within some sectors of the physician, public, legislative, and business communities that need to be addressed; now, therefore, be it

RESOLVED, that the KMA Board of Trustees continue studying the concept of collective bargaining under the "State Action Doctrine" and seek to determine its potential and viability within the Commonwealth of Kentucky; and be it further

RESOLVED, that the issue of physician collective bargaining under the "State Action Doctrine" be referred to appropriate KMA committees for development of legislation, education of physicians, patients, and business executives if indicated; and be it further

RESOLVED, that in accordance with the KMA House of Delegates' operating procedures during the Kentucky General Assembly, the introduction of legislation relating to the "State Action Doctrine" including the composition, priority, manner, and time of introduction be left to the discretion of the Chair of the KMA Committee on State Legislative Activities and the KMA Quick Action Committee.

RECOMMENDATIONS, REFERENCE COMMITTEE C:

Reference Committee C heard extensive debate regarding Resolution 128, State Action Doctrine, submitted by the Board of Trustees. Reference Committee C recommends that Resolution 128 be amended by deletion of the final Resolved. The reference committee was concerned about state regulatory bodies becoming more involved in the day-to-day practice of medicine. Reference Committee C therefore recommends that Resolution 128 be referred to the Board of Trustees as amended.

Two members of the Reference Committee have asked to make a minority report expressing their opposition to the resolution. The minority believes that anti-trust relief should be the KMA's highest priority. However, the minority opposes any solution which places physician contract negotiations under state control.

Action from the floor referred Resolution 128, in its original form, to the Board of Trustees.

RESOLUTION 99-131

National Patient Protection Legislation Board of Trustees

WHEREAS, in accordance with AMA House of Delegate's direction, with strong support from KMA, AMA officers and staff have been diligent in their efforts to seek passage of essential national patient protection laws; and

WHEREAS, AMA-supported principles include: requirements that only physicians should be allowed to make medical decisions; health plans should be held accountable for their actions which cause injury or death to patients; patients may appeal to an independent body of physicians for a final determination if care is delayed or denied; and that enacted protections should apply equally to every patient with private health insurance; now, therefore, be it

RESOLVED, that the KMA commends AMA officers and staff for their extraordinary efforts on behalf of patients and the profession; and be it further

RESOLVED, that KMA continues to urge the Kentucky Congressional Delegation to support the major principles of Patient Protection as defined by the AMA and KMA; and be it further

RESOLVED, that a copy of this resolution be forwarded to the AMA Chicago and Washington offices with KMA's acknowledgement and expression of gratitude; and be it further

RESOLVED, that a copy of this resolution be forwarded to every member of the Kentucky Congressional Delegation, thereby reaffirming our support for the principles of Patient Protection.

RECOMMENDATIONS, REFERENCE COMMITTEE C:

Reference Committee C next considered Resolution 131, National Patient Protection Legislation, submitted by the Board of Trustees. Reference Committee C recommends Resolution 131 be adopted.

Mr Speaker, I recommend the adoption of the report of Reference Committee C as a whole, as amended.

Mr Speaker, I wish to personally thank the other members of Reference Committee C for their assistance to the House of Delegates in trying to formulate equitable policies on some very worthy but controversial issues. Other members of this committee are: Gil L. Daley, MD, Hazard; Michael T. Macfarlane, MD, Louisville; Billy Joe Parson, MD, Somerset; Dale E. Toney, MD, Lexington; and William L. Tyler, III, MD, Owensboro. Reference Committee C would also like to personally thank Michelle Phelps for her assistance in preparing this report.

Respectfully submitted,
REFERENCE COMMITTEE C
Lela C. Maynard, MD, Pikeville, Chair
Gil L. Daley, MD, Hazard
Michael T. Macfarlane, MD, Louisville
Billy Joe Parson, MD, Somerset
Dale E. Toney, MD, Lexington
William L. Tyler, III, MD, Owensboro

Vice Speaker Slabaugh then called on President Stephens to introduce a special presentation. Dr Stephens noted that the Kentucky Physicians Care

Program, or Health Kentucky, had been in operation for approximately 15 years, and has become a model for the way other states provide care to the indigent. He reported that KPC is responsible for providing care to more than 300,000 needy individuals in every county of the state. A video was then shown to highlight the accomplishments of KPC over the past 15 years.

Following the video, Dr Stephens commended the more than 2,000 volunteer physicians who contribute their time to the program. Dr Stephens announced that the KMA Board of Trustees had made a commitment this year to seek 100% participation from House of Delegates members. That commitment began by ensuring every Trustee was a participating physician, and that objective has been met. Dr Stephens thanked all delegates who are currently participating in the program and encouraged all others to become involved in this worthwhile effort.

Danny Clark, MD, Somerset, Vice Chairman of the Kentucky Medical Insurance Company Board of Directors, presented an update on the status and activities of KMIC and its parent company, Mutual Insurance Company of America (MICOA). He reported that Marketing and Underwriting are working as a team on marketing and retention. In Kentucky, the retention rate for professional and liability policies is 91%. He also reported that KMIC has been sponsoring many continuing education activities, including risk management seminars. Dr Clark noted that to significantly affect premiums, physicians must become politically active to obtain meaningful tort reform.

The Speaker then announced winners of the KEMPAC raffle.

Editorial Note: Unless otherwise indicated, the reference committee recommendation on each report and resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE D

Susan G. Bornstein, MD, Louisville, Chair

26. Report of the Committee on Medicaid Managed Care
27. Report of the Committee to Investigate Changing Trends in Medicine
28. Report of the Young Physicians Steering Committee
29. Report of the Resident Physicians Section
30. Report of the Medical Student Section
31. Report of the Committee on Managed Care
32. Report of the KMA Membership Task Force
- Report of the Ad Hoc Committee on Cardiovascular Services
- Resolution 106 — All Products Clauses
(Board of Trustees)
- Resolution 108 — 2000 Member-Get-A-Member Campaign
(Board of Trustees)
- Resolution 110 — Managed Care Compliance
(Jefferson County Medical Society)
- Resolution 112 — Ban All Products Clauses in Kentucky
(Jefferson County Medical Society)
- Resolution 119 — Immunizations for Older Americans
(Resident Physicians Section)
- Resolution 124 — Claims Review Programs and Unilateral Offsets
(Jefferson County Medical Society)
- Resolution 125 — Service Reimbursement During Credentialing
(Jefferson County Medical Society)
- Resolution 133 — Claims Review Programs and Unilateral Offsets
(Board of Trustees)

ITEMS FOR CONSENT

Reference Committee D reviewed the following items and recommends they be filed, by consent of the House, without discussion:

26. Report of the Committee on Medicaid Managed Care — filed
 28. Report of the Young Physicians Steering Committee — filed
 29. Report of the Resident Physicians Section — filed
 30. Report of the Medical Student Section — filed
 31. Report of the Committee on Managed Care — filed
 32. Report of the KMA Membership Task Force — filed
 - Report of the Ad Hoc Committee on Cardiovascular Services — filed
- Reference Committee D would like to express its appreciation to the authors for their time and effort spent in preparing these reports for the House of Delegates.

Mr Speaker, Reference Committee D recommends adoption of the Consent Calendar as a whole.

Committee on Medicaid Managed Care

Due to the implementation around the state of Medicaid managed care, KMA created the Committee on Medicaid Managed Care, which monitors and reports to the Board of Trustees and membership on activities of the Cabinet for Health Services, Department of Medicaid Services, and the individual Medicaid partnership regions. The Committee is composed of physicians from each of the eight Medicaid regions around the state and met once during the past year.

Kentucky is changing the way Medicaid health care is delivered throughout the state. To replace the KenPAC program, the state has been divided into eight geographic regions, with each region having to develop a Medicaid "partnership" to deliver health care to the Medicaid population of the region. The state will give each region a specific amount of money each month, depending on the Medicaid population and other factors in the region, and the region will use the money as it sees fit to deliver health care to Medicaid recipients. The largest of these regions, Region 3 (Louisville) and Region 5 (Lexington), have already developed partnerships and have begun enrolling members in their plans. While the other regions outside of Louisville and Lexington have not yet formed partnerships for various reasons, it appears that the state would like all the regions to have a functional partnership by December 1, 1999. This report provides an update on each of the eight regions.

Regions 1 and 2 (Western Kentucky)

Region 2 spent approximately \$800,000 in start-up costs; hired an interim executive director; and seemed to have a risk partner. However, negotiations with the state were not fruitful and the decision to form a separate partnership was abandoned.

Since Regions 1 and 2 have such small numbers of lives, the two regions have met to discuss the possibility of combining or partnering with Region 3.

Region 3 (Louisville area)

Region 3 experienced a financial shortfall requiring additional capital of \$8 million from the owners. The partnership was, to quote its director, "financially fragile" and it was expected to continue to be so for several months. The partnership has also been infused with additional money from the state and may show a profit during the current year.

A considerable problem with financing the Region 3 Partnership, as well as the other partnerships, has been the pharmacy costs. To combat this problem, the Region 3 partnership has initiated a preferred-drug list; developed a preauthorization program for certain pharmaceuticals; and tried to identify physicians who are high prescribers and work with them to change their prescribing practices. The partnership has also hired a consultant to assist them in looking at the six major therapeutic classes in order to help identify patients who could receive alternative drugs which would decrease costs while maintaining the same quality of care.

Emergency room visits have also risen significantly due to the new requirement that all members who come to an emergency room requesting treatment must be seen by either a physician or a nurse designated to conduct a medical screening examination to determine whether care needs to be rendered. The Member Quality Access Committee was established by the partnership to address the problem of trying to control excessive emergency room utilization.

Region 4 (South Central Kentucky)

Region 4 considered forming a legal entity for the partnership, but there was a lack of interest to do so. The region does not have anyone in the area that is willing to take the necessary risk to establish a partnership. Progress in the area seems to be very slow and the region is still in the very early stages of development.

Region 5 (Lexington area)

The partnership has been up and running for over a year and has encountered a lot of the same issues as those addressed by Region 3. The biggest problem has been pharmacy costs, which are almost double what was originally estimated. While these costs are covered by withholdings from physicians, most of the funds have been used to cover these costs. The partnership



undertook many of the same efforts as Region 3 to cut pharmacy costs, but they are still having trouble trying to reduce such costs. The partnership was infused with an additional \$9.8 million by the state, which will be used to cover pharmacy costs and return half of the withholds to providers in the region.

There have been numerous complaints made by the area's health departments, which are struggling because a considerable number of the patients previously seen by the health departments have been assigned to primary care physicians by the partnership.

Regions 6 and 7 (Northern Kentucky)

Region 6 combined with Region 7 to form a partnership known as Partner Care. Combined, these regions have approximately 50,000 covered lives. The regions have received a "loan guarantee" from the federal government to help fund the development of the partnership.

Region 8 (Eastern Kentucky)

There were two groups in Region 8 vying for the opportunity to establish a partnership. One group is led by various providers and hospitals in the region and has been referred to as the Region 8 Partnership entity. The other group is financed by Centene Corporation out of St. Louis, Missouri, and is led by physicians and other providers in the region. This group calls itself Midsouth Healthcare.

Since there were two groups vying to set up a partnership, the state developed an RFP process that was aimed at the two entities the state felt were qualified to bid on the Region 8 managed care plan: the Region 8 Partnership entity and Midsouth Healthcare. The RFP responses were reviewed by seven judges and the scoring among the judges was very close. Midsouth won the scoring process and was chosen to submit an application to establish a partnership in Region 8. There was an outcry from providers in the region and the news media had a field day because there was the appearance that the partnership was given to a for-profit company, namely Centene. The Cabinet thought this would be divisive, so it reviewed contract regulations and decided to give the two groups one final attempt to get together to form a partnership. Both groups submitted letters of protest, but the RFP process was canceled. The state met with both groups separately on March 29 and gave them until April 30th to form a new entity or the RFP process will begin again. The two groups were not able to reach agreement and both filed lawsuits against the state.

Since that time, the state has developed another RFP and the two original entities, along with another one led by Pikeville Methodist Hospital, will submit proposals under the new RFP.

I wish to thank the members of the committee, as well as others from various regions who have met with the committee to discuss their projects. I would also like to thank Dennis Boyd, commissioner for Medicaid Services, and Richard Heine, Director of Medicaid Managed Care, for providing the committee with information.

Donald R. Neel, MD
Chair

Young Physicians Steering Committee

The Young Physicians Steering Committee focuses on the special concerns of young physicians, makes recommendations on ways in which organized medicine can be responsive to such concerns, and facilitates communication and interaction among young physicians.

This year the Young Physicians Steering Committee developed plans to pursue a number of activities. An obvious concern is the level of membership among young physicians, which is low. The Steering Committee strongly endorsed the Member-Get-A-Member Campaign and also discussed the barrier of cost for professional organization dues. It is noted that KMA is examining the possibility of employing different payment methods for young physicians, including installment payments or direct withdrawals, as well as considering joint dues when both spouses of the couple are physicians.

The Steering Committee initiated plans for the yearly forum held during the KMA Annual Meeting and developed issues to pursue for its presentation. Typically, this meeting occurs on the Tuesday of the Annual Meeting with a luncheon and formal presentation. It is likely that this format will be continued.

An issue that received some focus was the high failure rate among physicians taking board certification examinations for the first time. This

is of particular concern, as board certification is becoming more and more important to medical careers. One apparent issue is that if board certification examination failure rates are typically high, a question might be raised regarding deficiency in training. This concern was carried to the meeting of the American Medical Association Young Physicians Section for an ongoing study by that group. Some initial work has already been completed at the national level, but this is an issue that requires continued monitoring.

Routine communications with young physicians on topics of interest was felt to be a beneficial activity. The committee has undertaken some initial considerations of this effort with emphasis on development of an e-mail newsletter. A difficulty encountered has been acquisition of e-mail addresses, which must be obtained voluntarily. The Steering Committee will continue its efforts in this regard.

In an effort to develop interest, the Steering Committee felt that an activity to be pursued was development of family outings for young physicians in local areas. To this end, discussions have been held with local area groups, and an outing is planned in August to be cosponsored with the Fayette County Medical Society at Spindletop Farm. It was hoped that the provision of an informal social opportunity might encourage participation more than would a more formal venue.

The Steering Committee intends to continue seeking representation with the AMA Young Physicians Section. This is thought to be an excellent opportunity for communication as well as leadership development. The committee will continue to pursue ways to communicate, promote interaction with, and provide organizational opportunities to young physicians. The group sincerely appreciates the support and encouragement of the Board of Trustees.

Judy M. Linger, MD
Chair

Resident Physicians Section

The Resident Physicians Section has been involved in numerous activities at the state and national levels this year. Representatives from residency programs at the University of Louisville, University of Kentucky, Trover Clinic, and St Elizabeth's form the section's Governing Council which meets regularly to discuss matters of interest to residents in Kentucky. The council met three times this year and was represented at the KMA Annual Meeting as well as the AMA Annual Meeting.

The 1998 joint Annual Meeting of the KMA Medical Student Section and Resident Physicians Section, held September 22 in Louisville, dealt with Management Guidelines and Fraud and Abuse issues. Robert R. Goodin, MD, Louisville, and Patrick T. Padgett, JD, KMA Staff Council, addressed the students and residents on these issues.

At the council's March meeting, ideas were discussed on how to improve and increase attendance at this year's RPS-MSS Annual Meeting. Steve Hester, MD, President, presented his goals for this year and Jonathan Privett, MD, Delegate to the AMA Resident Fellows Section (AMA-RFS), reported on activities at the AMA-RFS interim meeting in December.

At the May meeting, new officers were elected and plans were made for the RPS-MSS Annual Meeting in September. At the next meeting, July 21, 1999, the council will finalize plans for the RPS-MSS Annual Meeting in September and discuss ways to increase resident involvement in KMA.

In late June, KMA again participated in the Housestaff Orientations at UK and UL. Through these efforts, over 50 residents joined the Association. We are grateful to those programs that allow KMA and the county societies to participate at Orientations.

Dr Privett also represented the section at the 1999 AMA-RFS Annual Meeting in Chicago. The RFS reaffirmed its commitment to reducing the financial burden on residents by asking the AMA to work with the federal government to seek federal income tax exemption for educational loan repayment programs for physicians practicing in underserved areas and lobby for full deferment of student loans through residency and fellowship. The section will develop a grassroots campaign to educate legislators about the debt burden on young physicians.

The RFS strongly opposed the recommendation of the Federation of State Medical Board's Report 98-5, which recommends that residents complete at least three years of training before they can obtain unrestricted licensure. They also oppose the recommendations by FSMB calling for medical

students and unlicensed residents to be reported to state licensing boards.

The Governing Council wishes to thank the KMA Officers, Board of Trustees, and House of Delegates for their continued support and for giving residents the opportunity to have a voice in issues affecting the future of our profession.

Steven T. Hester, MD
President

Medical Student Section

It is a pleasure to relay the activities of the KMA Medical Student Sections for the University of Louisville and University of Kentucky during the 1998-1999 academic year.

The 1998 joint Annual Meeting of the KMA Medical Student Section and Resident Physicians Section, held September 22 in Louisville, dealt with Management Guidelines and Fraud and Abuse issues. Robert R. Goodin, MD, Louisville, and Patrick T. Padgett, JD, KMA Staff Council, addressed the students and residents on these issues.

Both chapters had successful recruiting years through the AMA Outreach Program. The University of Louisville chapter received over \$2,400.00 for their efforts and the University of Kentucky received over \$1,700.00.

LaDonya Reed (UK President) and Kate Wilson (UL President) represented their schools at the KMA Board meetings and the AMA meetings. The 1999 AMA-MSS Annual Meeting proved to be very educational. This was an excellent opportunity to learn AMA's policy and interact with colleagues.

At this year's meeting the Medical Students Section adopted a resolution that instructs the section to investigate student concerns over the recent computerized USMLE Step 1, and to present recommendations to the NBME for improving the administration of the exam. Some students have faced technical difficulties while taking the computer-based version of the exam.

Thank you to the Kentucky Medical Association for acting as a resource. Your commitment to the success of the MSS chapters is appreciated.

LaDonya Reed
President, UK Chapter

Kate Wilson
President, UL Chapter

BOARD NOTE: *The Board of Trustees, reviewing this report at its meeting August 4-5, 1999, also commended the students and Dean of the Pikeville College School of Osteopathic Medicine for their support of KMA this year through 100% membership.*

Committee on Managed Care

The KMA Managed Care Committee was formed as a result of the KMA Strategic Plan and consists of the members of the former Committee on Medical Insurance and Prepayment Plans, as well as the KMA Physician's Plan (KMAPP) Board of Directors. The committee has been tasked to discuss Kentucky payer policies; meet with representatives of payers; discuss payer contracts; discuss and suggest training needs and priorities for physicians on business issues; review effectiveness of KMA Insurance Agency relative to the KMA member group health insurance plan; and serve as a forum for independent practice associations to discuss issues of common interest.

The committee met once during the year and discussed a number of items. Resolution 98-102, which dealt with case severity indexes, was referred to the committee. The committee expressed reservations about developing a model case severity indexing system until it could be established what types of indexing were currently being used by third-party payers. It was discovered that there is little being done in this area and the committee will again take up the issue at its next meeting.

The committee also addressed the issue of gag clauses in health plan contracts with physicians. While it appears most plans do not have such clauses in their contracts—partly because KMA supported legislation banning gag clauses in the last General Assembly—KMA published articles to the membership asking them to bring to the attention of KMA any gag clauses they find in their contracts. To date, no such reports have been received by KMA.

KMA greatly expanded the number of managed care seminars it offered throughout the year. KMA offered seminars in basic coding, advanced coding, advanced managed care, audit proofing a medical practice, getting started in medical practice, Stark laws, and corporate compliance plans. Other seminars that might be of interest to physicians include specialty coding, contract negotiation, capitation, and employment law.

Another issue taken up by the committee, and pursued by the KMA Board of Trustees, was the issue of "all products" clauses in health plan contracts with physicians. An all products clause is a clause in a health plan physician contract that requires, as a condition of participating in any of the health plan products, that the physician participate in all of the health plan products, present or future. Since health plan products differ substantially, it seems unfair to force physicians into participating in all of them. With the power health plans currently have in the marketplace, they are in a position to try and force such clauses on physicians, and this happened in a high-profile incident in Louisville. KMA wrote the state Insurance Commissioner asking that all products clauses be declared illegal, just as the Nevada Insurance Commissioner had done. KMA will also support legislation specifically banning such clauses in the future.

The committee recently added a medical manager to its ranks to give a different perspective on issues and will continue to work on managed care issues of interest to physicians. I appreciate the work of the committee, as well as the medical directors from the various health plans who have provided input over the past year.

William B. Monnig, MD
Chair

KMA Membership Task Force

Although the KMA Membership Task Force did not meet this year, several activities were undertaken and continued under its direction.

Appointed by the Board of Trustees in April 1997, the Membership Task Force was charged with a mission to (1) strengthen membership through recruitment of new members and retention of existing members and (2) encourage an increased level of participation in Association activities.

The 1999 Member-Get-A-Member Campaign was a very successful recruitment effort that not only resulted in 68 new Active members, but also involved more than 60 physician recruiters who made numerous peer-to-peer contacts. Initiated at the 1998 Annual Meeting, the campaign ended on March 1 with 17 recruiters qualifying for one of the four awards offered. We applaud the efforts of all who participated and specifically recognize in this report those who earned the top award—a laptop computer—for gaining 10 or more new members: Baretta Casey, MD, Pikeville, with 14 new members; Harry Carlross, MD, Paducah; James Wright, MD, Louisville, and a joint effort of the Fayette County Medical Society Executive Committee. The task force encourages all delegates and members to participate in the 2000 Member-Get-A-Member Campaign.

The KMA website—www.kyma.org—is another area initiated by the task force. It is a valuable resource providing members and the public information on legislative policy and links to state and federal legislators, legal resources, continuing medical education, the Annual Meeting, and important links to other medical sites. Expansion of the website has included a "Hot Topics" page alerting members to important and timely issues affecting their practice. Additional Annual Meeting information includes a list of exhibits and profiles on speakers. A "Members Only" section provides tools physicians can use in their practices, eg, sample legal documents, updates on fraud and abuse issues, Medicaid and Medicare alerts, etc. In addition, a roster of KMA members and a calendar of activities have been added to enhance the usefulness to the membership.

When the task force was appointed, it met on numerous occasions to envision future strategies for the Association by identifying barriers that would need to be overcome and offering opportunities that could be undertaken to achieve these goals. Because of the broad-based composition of the task force, a wide range of ideas and implementation goals were presented.

The goals and mission of the task force are now being addressed through the adoption and implementation of KMA's Strategic Plan, Future Search, and it is our recommendation that the task force not be reappointed.



We thank the Board for the opportunity to explore avenues that have impacted the future direction of KMA and commend its vision in undertaking and implementing a long-range strategic planning process.

Ardis D. Hoven, MD
Chair

Ad Hoc Committee on Cardiovascular Services

Late last summer, Anthem Blue Cross-Blue Shield announced a new Coronary Services Network to be implemented in qualifying hospitals. The program was highlighted as a "quality assurance" program to "prevent and treat coronary artery disease and perform original surgery correctly the first time." The program was to be directed to participating hospitals, which would have to meet and maintain qualification and volume standards. Services to be covered would be coronary artery bypass grafts, cardiac catheterization, angioplasty, and stent placement. The most obvious questionable criterion from KMA's standpoint was that a minimum of 200 of each procedure must be performed annually for facilities to qualify.

In September last year, the House of Delegates voiced concern about this network, the Quick Action Committee met with representatives of Anthem Blue Cross-Blue Shield shortly thereafter, and in November met with leadership of the Kentucky Hospital Association to discuss specific joint concerns. In December, the Board of Trustees appointed this ad hoc committee to study the issue and prepare a response for KMA on this and related efforts instituted by the carrier.

The ad hoc committee first met in February, with an external consultant, to initiate plans to actively address all concerns. Since that time, the ad hoc committee has met by conference call and through several postal communications. Likewise, your chairman and staff have met on numerous occasions with representatives of the Kentucky Hospital Association, Anthem Blue Cross-Blue Shield, and on two occasions with the Commissioner of Insurance. Through the joint efforts of KMA and KHA, the Commissioner was approached and became involved in the issue because of insurance implications and the health care reform statute relating to medical care delivery networks.

Major concerns that KMA and the Kentucky Hospital Association had with the network proposal were, again, volume performance standards; additional costs incurred by facilities to collect specific data for Anthem and costs otherwise involved; a lack of clear-cut criteria for review of hospitals by Anthem; no discernable provisions for nonqualifying hospitals to become able to participate; and questionable compliance with statutory requirements for medical service network operations. An additional major concern was the failure of Anthem to seek physician input prior to finalizing the selection criteria.

The Commissioner of Insurance coordinated a "hiatus" period among KMA, the hospital association and Anthem, so that discussions and resolution of areas of disagreement could be pursued. A main aspect of this moratorium was agreement by Anthem to delay the action of nonpayment to nonparticipating hospitals until the beginning of the year 2000. In these discussions, ten specific areas of concern were identified.

In mid-July the Commissioner of Insurance directed a letter to Anthem which amounted to a declaration of settlement, from his perspective, of the negotiation discussions that had occurred to that point.

Issues that are of most concern to physicians stated by the Commissioner are:

- Anthem will notify applicant hospitals of changes to standards as they occur and give participating and applicant hospitals sufficient time to comply with these changes;
- Anthem may continue to use proprietary weighted data to evaluate hospital qualification, but will pay for the initial data analysis and consider including subsequent analysis costs in reimbursement to hospitals;
- Anthem will conduct review of physician office data, instead of requiring the hospital to perform this function;
- The Commissioner has asked Anthem to be flexible in using procedure volume standards. This requirement should be considered along with other network requirements, but should not be a sole determining factor for participation.

- Anthem should develop procedures for hospitals just beginning cardiac programs that wish to apply for network participation in the future.

It does not appear that any facility with a committed intent of developing coronary service will be precluded under the current directives. The Commissioner's involvement does not have the force of law, but his declarations are obviously significant. It seems that physicians' concerns have been reasonably addressed to this point. Although the committee's work has been completed, continual monitoring will take place under the direction of the Board of Trustees.

Robert R. Goodin, MD
Chair

END OF CONSENT CALENDAR ITEMS

Committee to Investigate Changing Trends in Medicine

In 1998 the Kentucky Medical Association House of Delegates passed Resolution 98-104, which instructed the KMA to "consider the antitrust environment as it currently relates to medical practice, including what would and would not be allowable collective activity for physicians, and the role of organized medicine on a county, state, and national level." The Board of Trustees referred this issue to the committee to Investigate Changing Trends in Medicine.

INTRODUCTION

The antitrust laws have been interpreted to allow health plans such a high degree of leverage over physicians that an appropriate balance of interests no longer exists in the marketplace. This has caused concern among physicians and the public about the direction of our health care system since health plans now have the power to determine what kind of medical care is rendered to a patient, whereas that role was traditionally reserved to the physician. To correct the imbalance between physicians and health plans in the marketplace, physicians around the country are banding together in various ways to negotiate contract terms. The antitrust laws, however, prevent competing, independent physicians from conducting "collective bargaining," which in many cases leaves physicians no alternative but to negotiate on their own.

The Committee to Investigate Changing Trends in Medicine met to discuss these issues and report to the membership. To assist in the discussion, the committee received reports from Mike Cronan, Esquire, an attorney with the Louisville law firm of Stites & Harbison, and Todd Vande Hey, Vice President for Private Sector Advocacy with the American Medical Association. This report outlines the information conveyed to and discussed by the committee.

COLLECTIVE BARGAINING UNDER CURRENT LAW

In order for physicians to conduct traditional collective bargaining under federal law, physicians must be classified as "employees," which most are not. If a physician is classified as an employee, however, the physician may also be classified as a "supervisor" or member of "management" which also could preclude the physician from collectively bargaining. There is no bright-line test as to what constitutes an "employee." Some courts have found that physicians are supervisory employees when their decisions direct other members of the health care team, such as nurses and technicians. Other factors to consider include whether the alleged employer supplies the instrumentalities, tools, and place to work; sets the work hours and pays by time period or by procedure.

Self-employed physicians are not considered "employees" eligible for collective bargaining. They are generally considered to be independent contractors, entrepreneurs, or independent businesses who do not qualify to collectively bargain. However, in recent years, physicians in independent practice have lost considerable medical decision-making authority to health plans and hospitals. In addition, health plans have enough economic leverage that physicians often feel compelled to accept many other terms of dealing.

Physicians in independent practice may join with other physicians to form certain types of "networks" which can play limited bargaining roles with insurance companies. The most common form of network is the Independent Practice Association or IPA. Three key variables determine the permissible composition and role of networks: the market power of the physician

network and its physicians; whether the arrangement is exclusive (physicians may contract only through the IPA) or nonexclusive (physicians may contract with other IPAs or with payors directly); and, the type of financial risk that will be shared by the physicians through the IPA. The government has recognized a "safe harbor" for networks comprised of 20 percent or fewer of the physicians in a particular specialty with active hospital staff privileges who practice in the relevant geographic market and share substantial financial risk. An example of substantial financial risk is an agreement to provide services on a capitated basis or where the physician network provides financial incentives (such as "withholds") for its members to achieve cost-containment goals.

Physicians can legally engage in a number of collective activities through medical associations, which unions frequently offer members—short of the right to strike or collectively bargain. Such activities might include lobbying; providing contract reviews and information; providing other legal and regulatory information; and, providing a forum for all physicians to participate in the goals and policies of the association.

PROPOSED LEGISLATION

To help level the playing field in negotiations between health plans and physicians, various state and national medical associations are pushing for passage of state and federal laws that would allow physicians to collectively bargain.

State Action Doctrine

The American Medical Association recently drafted model state legislation that would allow physicians in a given state to collectively bargain, with some limitations. This legislation is based on a line of federal court cases that created an exception to the federal antitrust laws known as the "state action doctrine." In general, the state action doctrine says that antitrust laws do not apply to action by a state, or to private conduct compelled or approved by the state. In other words, where the requirements of the state action doctrine are met, behavior that would otherwise violate the antitrust laws will be exempt from antitrust scrutiny.

To qualify for this exemption, a private party, such as a physician, must act under a "clearly articulated and affirmatively expressed state policy" that must be spelled out in the state legislation, and the action (in this case, collective bargaining) must be subject to "active state supervision." In other words, the state must, in practice, exercise some degree of independent judgment or control over the activity. Passive or theoretical power of a state to review private action will be insufficient to meet this standard. "Active state supervision" in negotiations between a health plan and physician *might give the state input into the negotiations themselves*. Thus, by operating under the "state action doctrine," a certain amount of autonomy may be lost. Of course, the legislation would also allow all physicians, including self-employed physicians, the opportunity to collectively bargain with health plans.

Washington State has passed such legislation, but under its legislation, physicians may not collectively bargain for fees. The Washington State Medical Association has formed a "bargaining unit" for its membership to benefit from this law, but no group to date has used the negotiation service to conduct any negotiations with health plans. Texas also recently passed legislation under the "state action doctrine" that would allow physicians to collectively bargain, and would also allow collective bargaining for fees. The Texas Medical Association is currently waiting to see how the state will structure the negotiation process before it decides whether it will form a collective bargaining unit. Other state medical associations, including Pennsylvania, New Jersey, and Georgia are exploring the possibility of supporting similar legislation.

Federal Legislation

The American Medical Association is also pushing legislation on the federal level that would change federal antitrust laws to allow physicians to collectively bargain. HR 1304, commonly known as the Campbell Bill, would modify the antitrust laws to allow individual physicians to engage in joint negotiations with health plans. Health plans would still have the ability to approach physicians individually and try to persuade them to contract with the plan, but the physicians could also agree that they would not contract individually unless a satisfactory contract is negotiated by the group. AMA reports that there is optimism regarding passage of the bill, although it might be changed from its current form. How such a law would affect a physician's ability to negotiate in a state that has passed legislation

under the "state action doctrine" is unknown. It is also not known how such legislation would affect the bargaining position of existing IPAS.

AMA COLLECTIVE BARGAINING UNIT

In 1998 the AMA House of Delegates directed the AMA Board of Trustees to develop a negotiating unit, within organized medicine, but without any affiliation with national trade unions, and free of antitrust constraints. Its purpose was to help all members level the playing field in negotiations with health care payers. In accordance with this directive, the Board evaluated the development of a Collective Bargaining Unit and recommended to the House of Delegates in 1999 that the AMA not form a labor organization. The House of Delegates, however, voted once again to do so and AMA is now in the process of forming such an organization. The new labor organization is not for all physicians. Instead, it will represent employed physicians and, where allowed, residents.

The following outlines the essential nature and characteristics of the AMA's collective bargaining Unit (CBU).

i. Operating Parameters

- The CBU would be established by the AMA and the AMA would appoint the CBU's Board for the first five years. The law calls for the members of the CBU to elect the Board after five years. The CBU would be a legally distinct, separate entity from the AMA itself, and the AMA would not be able to exert control over its policies and actions.
- The CBU would be established as a professional alternative to organized labor.
- All members, officers, and units of the CBU would follow the Principles of Medical Ethics and the opinions of the Council on Ethical and Judicial Affairs, specific provision not to strike, nor to affiliate with non-physicians.
- The CBU would not organize physician owned and operated group practices, so as not to represent some AMA members against others.
- It would not be legal to require members of the CBU to be members of the AMA (although a CBU could bargain for payment of AMA dues by employers as a benefit).

ii. Issue Agendas

- Appropriate role in governance
- Quality/patient care concerns (eg support staff; closing of facilities)
- Equipment and technology needs
- Productivity Standards
- Terms and conditions of employment
- Hours
- Coverage
- Clinical autonomy
- Respect
- Legal and ethical responsibility to meet professional commitments
- Evaluation criteria
- Compensation

iii. Negotiating/Bargaining Tools and Tactics to be used by the CBU

- Collective negotiation and bargaining.
- Informational pickets.
- Nondisruptive public demonstrations.
- Lobbying and publicity campaigns.
- Unfair labor practice petitions.
- Free days—provide free services to patients of the employers thereby reducing revenue to employer without disrupting care.

The issues on which collective bargaining would take place under the AMA's CBU would be different for residents in some respects, and would include the following:

- Work hours, taking into account the educational needs of the residents and patient safety
- Work environment issues regarding safety and general well-being of residents
- Grievance procedures
- Fairness in evaluations
- Support staff
- Closing of facilities and residency programs
- Equipment and technology needs
- Productivity standards



- Quality of the educational experience
- Relationships with the faculty and administration
- Compensation

James R. Bean, MD
Chair

RECOMMENDATIONS

1. The committee recommends that the KMA Board of Trustees and the KMA Committee on State Legislation continue to monitor whether support and passage of legislation under the "state action doctrine" is desired by physicians within the Commonwealth, given the fact that the state may be able to participate in the negotiations between physicians and health plans.
2. The committee further recommends that the KMA membership be offered more educational information on the issue of collective bargaining so an informed decision can be made as to whether to pursue legislation under the "state action doctrine."

RECOMMENDATIONS, REFERENCE COMMITTEE D:

Reference Committee D considered the Report of the Committee to Investigate Changing Trends in Medicine. Reference Committee D recommends the adoption of Report No. 27 and its Recommendations.

RESOLUTION 99-106

All Products Clauses Board of Trustees

WHEREAS, health insurance companies have tremendous power in setting terms in contracts with physicians; and

WHEREAS, one of the clauses many health insurance companies use to attempt to further control the marketplace, and physicians, is the so-called "all products" clause; and

WHEREAS, the all products clause is a clause that requires, as a condition of participating in any of a health plan's products, that the physician participate in all of the health plan's products, present or future; and

WHEREAS, health plan products differ substantially in operation, including some that require physicians to assume a great deal of risk, which may not be a viable business option for smaller practices; and

WHEREAS, such clauses also require physicians to accept future contracts with unknown and unpredictable business risk that a reasonable person with any negotiating power would not agree to; and

WHEREAS, such clauses can disrupt and/or sever existing physician-patient relationships, which occurred in Louisville; and

WHEREAS, the health plan market continues to consolidate, and where plans have significant market share, such clauses will operate to further limit patient choice by facilitating a conscious push of patients into HMOs; and

WHEREAS, the United States Department of Justice has declared in court documents that a health plan's use of "all products" clauses can be used to unduly "depress physician reimbursement rates . . . likely leading to a reduction in quantity or degradation in quality of physicians' services" and that such a degradation in the quality of physician services may violate federal antitrust laws; now, therefore, be it

RESOLVED, that KMA believes that insurance companies' use of "all products" clauses is disruptive to the physician-patient relationship and supports legislation prohibiting "all products" clauses; and be it further

RESOLVED, that KMA educate physicians on how "all products" clauses can create potential financial liability, affect the quality of care provided to patients, and affect the health insurance market in such a way that a single insurance company could dominate the health insurance market.

RESOLUTION 99-112

Ban All Products Clauses in Kentucky Jefferson County Medical Society

WHEREAS, monopsony is the term in market economics for excessive concentration of purchaser power to the extent that the purchaser can dictate the seller's basic ability to offer services, and the price and terms of any sale; and

WHEREAS, rapid consolidation in the health insurance marketplace currently is giving insurers unprecedented power over the physicians with whom they contract; and

WHEREAS, insurance companies typically claim physicians have the freedom to terminate any provider contract with terms or conditions unfavorable to their practice, with a take-it-or-leave-it approach, while they ratchet down reimbursements; and

WHEREAS, current research is demonstrating that even a small percentage increase in an insurance company's market share can make it economically impossible for a physician to discontinue participation with that plan; and

WHEREAS, an "all products" or "all or nothing" clause requires physicians to participate in every product the plan offers with terms, reimbursements and conditions dictated by the plan, in order for the physician to participate in any of the plan's products; and

WHEREAS, such a one-sided control threatens physicians with economic failure on the one hand, and patients with disruptions in the physician-patient relationship and severe access problems on the other; now, therefore, be it

RESOLVED, that the Kentucky Medical Association establish as a primary legislative goal the prohibition of the "all products" or "all or nothing" clause in Kentucky health insurance provider agreements; and be it further

RESOLVED, that the KMA, together with its county medical societies, inform the public of the pernicious effects of the all products clause; and be it further

RESOLVED, that the KMA work with other state medical associations, specialty societies, and the AMA to seek a federal ban on the all products clause.

RECOMMENDATIONS, REFERENCE COMMITTEE D:

Reference Committee D reviewed Resolution 106, All Products Clauses, submitted by the Board of Trustees, and Resolution 112, Ban All Products Clauses in Kentucky, submitted by the Jefferson County Medical Society. These resolutions were considered together as they dealt with the same subject matter.

Reference Committee D recommends that Resolution 112 be amended by changing the last word of the first Resolved from "primary" to "key." The Resolved would then read as follows:

RESOLVED, that the Kentucky Medical Association establish as a ~~primary~~ key legislative goal the prohibition of the "all products" or "all or nothing" clause in Kentucky health insurance provider agreements; and be it further

Reference Committee D recommends the adoption of Resolution 112, as amended, in lieu of Resolution 106.

RESOLUTION 99-108

2000 Member-Get-A-Member Campaign KMA Board of Trustees

WHEREAS, sustaining and increasing membership in organized medicine is a crucial concern at all levels of the federation; and

WHEREAS, the recruitment and retention of all physicians, residents and students in Kentucky is a full-time, year-round effort; and

WHEREAS, the KMA 1999 Member-Get-A-Member Campaign resulted in more than 65 new active members; and

WHEREAS, more than 60 KMA members participated as recruiters; and

WHEREAS, this successful campaign proves that peer-to-peer recruitment is a powerful tool in convincing nonmember colleagues to join; and

WHEREAS, the Member-Get-A-Member Campaign for 2000 will also include recruitment of members for the American Medical Association; now, therefore, be it

RESOLVED, that each member of the KMA House of Delegates personally support the 2000 Member-Get-A-Member campaign by committing to recruit at least one new member in the KMA and/or AMA; and be it further

RESOLVED, that every KMA member be encouraged to urge nonmember colleagues to support the efforts of organized medicine at all levels through membership.

RECOMMENDATIONS, REFERENCE COMMITTEE D:

Reference Committee D next considered Resolution 108, 2000 Member-Get-A-Member Campaign, submitted by the Board of Trustees.

Reference Committee D recommends that Resolution 108 be adopted.

RESOLUTION 99-110**Managed Care Compliance
Jefferson County Medical Society**

WHEREAS, the requirements of insurance companies in the managed care environment have placed additional administrative burdens on the medical office; and

WHEREAS, the insurance carriers are requiring increasing numbers of preauthorizations for testing ordered by the treating physicians; and

WHEREAS, the burden of time, both for the office personnel and the physician, is interfering with the care of other patients; now, therefore, be it

RESOLVED, that the Kentucky Medical Association seek to establish that the criteria for approval of testing be provided to physician offices by all third-party carriers; and be it further

RESOLVED, that if a procedure requires precertification, the medical office should be entitled to payment for the extra administrative cost encountered in obtaining said approval; and be it further

RESOLVED, that if denial of a procedure is made, the carrier have a published appeals procedure that can be completed within three working days, so that the medical care of the patient is not delayed, placing the medical office at jeopardy for mismanagement of the patient's care.

RECOMMENDATIONS, REFERENCE COMMITTEE D:

Reference Committee D considered Resolution 110, Managed Care Compliance, submitted by the Jefferson County Medical Society.

Reference Committee D recommends that Resolution 110 be adopted.

RESOLUTION 99-119**Immunizations for Older Americans
KMA Resident Physicians Section**

WHEREAS, some older Americans incur pain and suffering from preventable diseases due to lack of immunization; and

WHEREAS, the long-term health care costs related to preventable diseases continue to rise; and

WHEREAS, this population needs more education and awareness of the need for immunizations; now, therefore, be it

RESOLVED, that KMA urge physicians to encourage immunizations of the elderly; and be it further

RESOLVED, that KMA work with appropriate government agencies and interested advocacy groups to promote public awareness of immunizations of the elderly.

RECOMMENDATIONS, REFERENCE COMMITTEE D:

Reference Committee D considered Resolution 119, Immunizations for Older Americans, submitted by the Resident Physicians Section.

Reference Committee D recommends that Resolution 119 be adopted.

RESOLUTION 99-124**Claims Review Programs and Unilateral Offsets
Fayette County Medical Society**

WHEREAS, insurance entities are instituting internal policies requiring review of claims to determine if documentation supports the level of service submitted and requesting repayments or performing unilateral offsets for services already performed; and

WHEREAS, the only basis for these reviews appears to be economic gain for the insurance entity, as no other criteria has been established; and

WHEREAS, this systematic scrutiny of physician claims and payments unfairly penalizes the financial integrity of the physician organization; and

WHEREAS, most insurance contracts have a timely filing deadline for physicians; now, therefore, be it

RESOLVED, that the Kentucky Medical Association affirms its support of a contract clause that establishes set rules for payment adjustments; and be it further

RESOLVED, that the Kentucky Medical Association affirms its support of claims review based only on a utilization method that identifies outliers; and be it further

RESOLVED, that the Kentucky Medical Association work legislatively and administratively to establish rules for retrospective payment adjustment by third-party payers and to eliminate automatic downcoding.

RESOLUTION 99-133**Claims Review and Unilateral Offsets
Board of Trustees**

WHEREAS, insurance companies are increasingly seeking refunds on claims already paid, in some cases claims paid three to five years earlier; and

WHEREAS, to demand a refund on a claim that was paid months or years earlier places an inequitable burden on the patient; and

WHEREAS, insurance companies' systems should be able to detect claim errors when the claim is submitted and provide the physician with information regarding the error; and

WHEREAS, once a claim is paid, insurance companies should be prevented from demanding repayments since the insurance company had the opportunity to review the claim when the claim was submitted; and

WHEREAS, some insurance companies are instituting internal policies that unilaterally offset and downgrade all claims submitted for Levels IV and V Evaluation and Management services; and

WHEREAS, some insurance companies require physicians to provide documentation for all claims submitted for Levels IV and V Evaluation and Management services; and

WHEREAS, after documentation is supplied to the insurance company to support a Level IV or V service, the insurance company still offsets the claim to pay only for a Level III service; and

WHEREAS, the companies reviewing the documentation for the insurance companies are often not subsidiary companies of the insurance companies, are not located in the same state, do not have experience in reviewing such claims, and cannot adequately review all Level IV and V claims because of the sheer volume of such claims submitted nationwide; and

WHEREAS, the companies who offset Level IV and V claims and demand supporting documentation for a Level IV and V claim say that Kentucky's law requiring claims to be paid within 30 days of submission of a claim does not apply until supporting documentation is received and reviewed; and

WHEREAS, Kentucky law requires claims to be paid within 30 days of the date a claim is submitted, not reviewed by the insurance company; now, therefore, be it

RESOLVED, that the Kentucky Medical Association encourage physicians to review their contracts with third-party payers to ensure that set rules for payment adjustments are established; and be it further

RESOLVED, that the Kentucky Medical Association seek legislation to require insurance companies to inform physicians when a claim has errors; and be it further

RESOLVED, that insurance companies be prevented from seeking repayment for claims more than one year from the date the original claim was paid; and be it further

RESOLVED, that the Kentucky Medical Association and the Federation of Medicine oppose any attempts by insurance companies to unilaterally offset claims until the company has reviewed the claim; and be it further

RESOLVED, that the Kentucky Medical Association affirm its support of claims review based on a statistically valid deviation from the community standard of care.

RECOMMENDATIONS, REFERENCE COMMITTEE D:

Reference Committee D reviewed Resolution 124, Claims Review Programs and Unilateral Offsets, submitted by the Fayette County Medical Society, and Resolution 133, Claims Review Programs and Unilateral Offsets, submitted by the Board of Trustees. These resolutions were considered together as they dealt with the same subject matter. Both resolutions contained constructive elements. The reference committee recommends a combination of concepts from both resolutions to constitute a new Substitute Resolution to read as follows:

RESOLVED, that the Kentucky Medical Association affirms its support of a contract clause that establishes set rules for payment adjustments; and be it further

RESOLVED, that the Kentucky Medical Association seek legislation to require insurance companies to inform physicians within 30 days when a claim has errors; and be it further

RESOLVED, that insurance companies be prevented from seeking repayment for claims more than one year from the date the original claim was paid; and be it further



RESOLVED, that the Kentucky Medical Association and the Federation of Medicine oppose any attempts by insurance companies to unilaterally offset or automatically downcode claims until the company has reviewed the claim; and be it further

RESOLVED, that the Kentucky Medical Association affirm its support of claims review based on a statistically valid deviation from the community standard of care.

Reference Committee D recommends the adoption of this Substitute Resolution in lieu of Resolution 124 and Resolution 133.

An amendment to the Reference Committee Substitute was offered from the floor of the House replacing the third Resolved with the following text:

RESOLVED, that insurance companies be held to the same time-frame in seeking repayment for claims as they require for submission of claims.

The Reference Committee Substitute Resolution, as amended on the floor of the House, was adopted in lieu of Resolutions 124 and 133.

RESOLUTION 99-125

Service Reimbursement During Credentialing Fayette County Medical Society

WHEREAS, physician credentialing sometimes requires extended, time-consuming efforts when data sources are nonresponsive or provide only partial or inaccurate data; and

WHEREAS, credentialing requirements by different authorities of influence may not be consistent within the same hospital or medical community; and

WHEREAS, some insurance carriers and other payers will not reimburse physicians for services provided while the credentialing process is in progress; and

WHEREAS, this policy can constitute a hindrance to patient care, is inequitable to physicians and has no relation to appropriateness or quality of care; now, therefore, be it

RESOLVED, that third-party payers should provide reimbursement for covered services rendered while a physician is undergoing the credentialing process.

RECOMMENDATIONS, REFERENCE COMMITTEE D:

Reference Committee D recommends that Resolution 125 be amended by the addition of a second Resolved that would read as follows:

RESOLVED, that the Kentucky Medical Association work with the Resident Physicians Section and the Residency Program Directors to encourage their residents to begin the licensing and credentialing process as early as possible.

Reference Committee D recommends the adoption of Resolution 125 as amended.

Mr Speaker, Reference Committee D recommends the adoption of the Report of Reference Committee D as a whole, as amended.

Mr Speaker, I want to personally thank the other members of Reference Committee D for their assistance to the House of Delegates in formulating policies on some very worthwhile issues. Members of the committee were: Sharon M. Colton, MD, Evarts; Marshall G. Howell, III, MD, Henderson; N. Roger Jurich, MD, Prestonsburg; Lucian Y. Moreman, MD, Elizabethtown; and John D. Stewart, II, MD, Lexington. I would also like to thank Debbie Cunagin for her assistance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE D
Susan G. Bornstein, MD, Louisville, Chair
Sharon M. Colton, MD, Evarts
Marshall G. Howell, III, MD, Henderson
N. Roger Jurich, MD, Prestonsburg
Lucian Y. Moreman, MD, Elizabethtown
John D. Stewart, II, MD, Lexington



Editorial Note: Unless otherwise indicated, the reference committee recommendation on each report and resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE E

Barbara A. Phillips, MD, Lexington, Chair

33. Report of the Committee on Maternal and Neonatal Health

34. Report of the Technical Advisory Committee on Physician Services (Title XIX)

35. Report of the Committee on Community and Rural Health

36. Report of the Committee on Physical Education and Medical Aspects of Sports

37. Report of the Committee on Child and School Health

38. Report of the Judicial Council

Report of the Ad Hoc Committee on Tobacco Settlement Funds

Resolution 109 — Health Education Curricula

(Thomas L. Young, MD, President, Kentucky Chapter, American Academy of Pediatrics)

Resolution 111 — Repeal State Mandated Procedural Counseling

(Jefferson County Medical Society)

Resolution 114 — Expand Medical Practice Act to Hold that Medical Review is the Practice of Medicine

(Jefferson County Medical Society)

Resolution 118 — Tobacco Settlement Allocation

(Jefferson County Medical Society)

Resolution 122 — Infection Control in the Cosmetic Industry

(Jefferson County Medical Society)

Resolution 123 — Kentucky State Licensure Requirement for

International Medical Graduates

(Rajesh K. Sheth, MD, Kentucky Indiana Association of Physicians from India and American College of International Physicians)

ITEMS FOR CONSENT

Reference Committee E reviewed the following items and recommends they be filed, by consent of the House, without discussion:

34. Report of the Technical Advisory Committee on Physician Services (Title XIX) — filed

36. Report of the Committee on Physical Education and Medical Aspects of Sports — filed

Mr Speaker, Reference Committee E recommends adoption of the Consent Calendar as a whole.

Technical Advisory Committee on Physician Services (TITLE XIX)

The Technical Advisory Committee on Physician Services (Title XIX), (TAC) is one of 11 provider groups represented on the Advisory Council for Medical Assistance, which advises the Secretary for Health Services on Medicaid issues. The TAC meets as needed to discuss and evaluate problems and concerns faced by physicians when dealing with the Medicaid program. If the TAC determines that the issues discussed require action, they are presented in a report to the Advisory Council for action. The TAC meetings are subject to the provisions of KRS 61.805-61.850, the Kentucky Open Meetings Law, which requires all TAC meetings to be open to the public and scheduled to allow effective public observation and media coverage.

The TAC met one time during the past year and discussed a wide range of issues. A representative from the Cabinet for Health Services reported on the work being done by Sapient, a company hired by the Department for Medicaid Services to review Medicaid claims for potential fraud and abuse. For this work, Sapient will be given a percentage of the money it recovers from medical providers, but that percentage was reduced to a staggered 15, 18, and 20% because of media and legislative complaints that the initial figure was too high.

Sapient will review all Medicaid claims from the previous five years using computer software. The software looks for billing patterns of individual providers that are outside of normal patterns and provides such information to the Medicaid Office of Inspector General. The OIG then has Sapient refine the data and the groups meet with the United States Attorney's office to discuss the data. At that meeting, it is decided which organization will pursue a particular case, whether it is civil or criminal. With cases that are considered billing errors, a letter is sent to the provider requesting a refund. The provider then has 30 days to appeal or 60 days to make payment. The

state officials indicated that Sapien will also be looking at recipient fraud in addition to provider fraud.

The committee also discussed whether UNISYS will be the third-party administrator for the Medicaid program. In testimony before the Medicaid Advisory Council, Medicaid Commissioner Dennis Boyd said that UNISYS' contract may not be renewed. According to Medicaid officials, while the contract with UNISYS was not extended, it was rebid and UNISYS won the bidding process. The contract will be effective December 1, 1999, and UNISYS will be paid \$1.6 million per month for their services.

The committee received reports on the various Medicaid managed care partnerships being established around the state. Regions 1 and 2 (Western Kentucky) are discussing the possibility of combining with Region 3 (Louisville). Regions 6 and 7 (Northern Kentucky and Northeastern Kentucky) have also combined and have received "loan guarantees" to help establish their partnership. The partnership will be run in conjunction with a company called PartnerCare, Incorporated. In Region 8 (Southeastern Kentucky), two entities responded to the initial RFP sent out by the state. One of the entities was chosen, but the other filed suit and the offer to the entity chosen was then withdrawn by the state. The winning entity then sued. The state has now refined the RFP and will send it out to three entities.

The committee was told that, because of its recommendation to the Medicaid Advisory Council, the Medicaid program would begin reimbursing physicians for work done by physician assistants. A regulation to that effect was recently passed.

I would like to thank the representatives from the Medicaid Department for providing the committee with information, and I would also like to thank the members of the committee for their work during the year.

Salem M. George, MD
Chair

Committee on Physical Education and Medical Aspects of Sports

The Committee on Physical Education and Medical Aspects of Sports deals with matters relating to the health and safety of elementary, middle, and high school students engaged in physical education and sports. It collaborates with and recommends programs to the KMA Board and advises the Kentucky Department of Education, the Kentucky High School Athletic Association, and other agencies and physicians of medical aspects of physical activities engaged in by our student athletes.

An ongoing and primary effort of the committee is to sponsor and oversee seminars annually, which high school coaches and athletic trainers are required to attend. In cooperation with the Kentucky High School Athletic Association (KHSAA), the committee solicits sponsors for these seminars, develops mandatory criteria, and conducts oversight and evaluation. Attendance by coaches and trainers at these seminars is required to maintain their certification for participation in KHSAA-sanctioned activities.

Over the years, it has been appropriate to periodically evaluate the conduct and content of these seminars, and this year the committee gave close study to possible changes. A traditional difficulty has been the overlap of seminars in given geographical areas and the provision of make-up seminars for individuals unable to attend those symposia offered in their local areas. Because of the prevalence of opportunities, the committee decided to eliminate make-up seminars. Likewise, because of the proven need for core content, the length of seminars was shortened to four hours to make the presentation of required material more relevant. To maintain consistency among the seminars, the committee felt topics and format for a program should be stipulated, with the allowance for some local flexibility, but that the topic list should be reviewed each year. The committee agreed on curriculum topics for 1999, and these were transmitted to all contact individuals conducting local seminars.

The KHSAA has required coaches to also receive cardiopulmonary resuscitation training, which has routinely been provided at these seminars. Rather than supplying or endorsing a specific CPR education provider, the committee felt it most appropriate for such decisions to be made by KHSAA.

Working with the Department of Education, the committee provided input in and comments on proposed revisions to state regulations governing medical examinations of interscholastic athletes. The regulation revision was

required because of changes in statutes by the 1998 session of the Kentucky General Assembly. These legislative changes included an increase from two to three in the number of examinations required for all school children throughout their scholastic careers, some modification of the specific examination factors being conducted, and the necessity for athletic examinations to be conducted by physicians. These recommendations were passed on to the Department of Education.

In discussion of this issue, the committee has been directed by the Executive Committee of the Board of Trustees to consider the physical/clinical difficulties sometimes associated with the conduct of these physicals. In future meetings the committee will attempt to develop suggested guidelines for physical examination site needs and their impact on the ability to perform appropriate clinical examinations.

Most members of the committee, and many team physicians throughout the state, have contributed many hours and many years of service to high school athletes. In recognition of this service, the committee is considering the possibility of developing lifetime passes to all state high school sporting events for long-standing team physicians. If this can be accomplished, it will be a small token of appreciation for the dedication that they have shown.

As the chairman, I would like to once again thank all the members for their dedicated and loyal service to the committee as well as to their local schools. They are due further recognition and thanks for their years of efforts to our school systems and student athletes.

R. Quin Bailey, MD
Chair

END OF CONSENT CALENDAR ITEMS

Committee on Maternal and Neonatal Health

The Committee on Maternal and Neonatal Health reviewed a number of issues this year, considered a good deal of information, and has developed recommendations for medical practice concerns and organizational attention.

The committee was able to exchange a good bit of information with the state Division of Adult and Child Health through its Director, James S. Davis, MD. A number of programs are underway that include Doctor Davis' division, affected medical specialty groups, and several of the members of the committee. Based on these discussions, the committee has developed what is felt to be a medical consensus that should be shared with the entire membership.

An ongoing concern of physicians is the fatality among low-birth-weight babies, and the obvious causative factor of perinatal smoking. Probably no single answer exists to resolve this issue, but some efforts underway have been a concerted perinatal smoking cessation program, the approval of smoking cessation pharmaceutical aids and behavioral counseling. Efforts are currently being made to have smoking cessation pharmaceutical products approved for the Medicaid Formulary, as well as the inclusion of behavioral counseling as a possible Medicaid-covered service. One possible way to assist in this situation would be the allocation of tobacco settlement funds to these efforts.

Another factor of influence on maternal and child health is the significance of folic acid intake by all women of childbearing age. A statewide task force is currently pursuing educational efforts directed at women of childbearing age, which includes representatives from the state chapter of the American College of Obstetrics-Gynecology, the Kentucky Pediatrics Society, the Kentucky Perinatal Association, the March of Dimes, and others.

Based on input from a number of sources, the KMA committee joins a consensus in expanding the screening program for newborns to include congenital adrenal hyperplasia. It is a collective view that this test should become routine for all newborns.

On a related issue, the Early Periodic Screening Diagnosis and Testing program (EPSDT) operated through state government, has been given close review in recent years. Physicians traditionally have not participated in large numbers in this program for a variety of reasons, which include program compliance difficulties. Efforts continue to be made to remove or mitigate bureaucratic, nonclinical barriers to physician participation. The committee strongly supports this effort because of the importance of early screening.



A very positive effort initiated by the Governor has been the promotion of Early Childhood Development Programs and creation of a task force, which has been subdivided into three environments. These three subdivisions are: 1) the "Prenatal Environment" (prior to conception up until birth); 2) "In-Home Environment" (birth to school age), and 3) "School and Community Environment."

The Governor will seek adequate funding to carry out the intent of this effort in the creation and operation of programs across the state. While these efforts will be carried on through state agencies, the precedents they create will, hopefully, bring attention to and expand the focus to all sectors of medical care delivery.

The committee gave quite a bit of attention to private/public partnerships and maximizing the appropriate use of health department resources. While a traditional controversy between privately practicing physicians and health departments has existed to some degree, limited resources necessitate that both segments should seek cooperative arrangements that recognize the capabilities and limitations of both.

In some areas, collaboration between the public and private sectors has resulted in some very effective delivery of medical services where, on a voluntary basis, physicians have offered their services in return for access to the health department's expensive technical equipment. Conversely, health departments have been effective in areas such as providing classes on diabetes and asthma to the affected patients. Other collaborative arrangements range from local private practice physicians arranging for night and weekend coverage for health department services, to limited contracts made with local physicians to provide specific services to local Medicaid populations.

The committee feels strongly that development of public/private partnerships to meet changing health delivery needs is very important. The committee recommends that KMA play an active role in beginning such partnerships through collaboration with the Cabinet for Health Services and through encouragement of physicians to initiate these sorts of efforts locally.

The committee will continue to monitor all of these activities, and will participate as individuals in their local areas. Likewise, the organization should maintain formal scrutiny and collaboration with all affected agencies that serve the needs of maternal and neonatal patients.

Ronald J. Lubbe, MD
Chair

RECOMMENDATIONS:

1. The committee recommends that KMA adopt as policy the importance of perinatal smoking cessation, folic acid intake by women of child-bearing age, and the importance of newborn screening for congenital adrenal hyperplasia.
2. The committee recommends that KMA formally participate with the Cabinet for Human Resources in the development of appropriate public/private partnerships, and that KMA encourage physicians to make similar efforts in their local areas.

RECOMMENDATIONS, REFERENCE COMMITTEE E:

Reference Committee E considered the Report of the Committee on Maternal and Neonatal Health and its Recommendations.

Reference Committee E recommends amendment of the Recommendations by addition and deletion, as follows:

RECOMMENDATIONS:

1. The committee recommends that KMA adopt as policy the importance of perinatal smoking cessation and folic acid intake by women of child-bearing age; and the importance of The committee recommends further evaluation of the utility of newborn screening for congenital adrenal hyperplasia.
2. The committee recommends that KMA formally participate with the Cabinet for Human Resources in the development of appropriate public/private partnerships, and that KMA encourage physicians to make similar efforts in their local areas.
3. The committee recommends that KMA actively seek participation in the Governor's Early Childhood Development Program.

Reference Committee E recommends that Report No. 33, with its Recommendations, be adopted as amended.

In discussion on the floor of the House clarification was offered for the phrase "public/private partnerships" appearing in Recommendation 2 of Report No. 33. It was explained that this referred to arrangements made between health departments and local physicians.

Committee on Community and Rural Health

The Community and Rural Health Committee met on one occasion this year to discuss various health and safety issues.

The committee considered Resolution 110, Confined Animal Feeding Operations (CAFOs), which was referred for evaluation and recommendations to the Board on the issue of the potential adverse public health impact of CAFOs. The author of the resolution, John A. Patterson, MD, Irvine, met with the committee and, after discussion on current activity at the state level, withdrew the resolution.

Dr Patterson was invited to use the Community and Rural Health Committee as a forum for informing the membership of agricultural and environmental issues. As a representative to Partners for Family Farms and the Health and Agriculture Forum, Dr Patterson noted that this will provide an opportunity for the medical and public health communities to influence agricultural diversification. He shared his concerns over the harm that factory farms have had on human health, polluting water and air quality, and destroying aquatic life. Dr Patterson also reported on the emerging global environmental crisis, ie, global warming, persistent organic pollutants, and biodiversity loss.

The committee also considered timely issues related to public health in the Commonwealth. Rice C. Leach, MD, Commissioner of Public Health, reported on statewide efforts of health departments and noted that 30% of their work is in environmental areas. The Department of Public Health is undertaking a campaign to meet with local medical communities to address the changing role of health departments and to work on collaborative efforts in caring for the citizens of this Commonwealth.

The Board last year, upon recommendation of the Community and Rural Health Committee, endorsed the Doctor Smokestopper Project, a joint effort with the Kentucky Division of Substance Abuse and other public health entities. Don Coffey, from the Division, coordinated the project with the Regional Prevention Centers in the state.

The project involved interviews with 630 primary care physicians in 86 Kentucky counties during September-November 1998. Findings of the survey affirm that Kentucky physicians use their influence to promote patient health concerning use of tobacco. Patient education tools were also made available to physicians through the KMA website and *Journal*.

Melinda Rowe, MD, President of the Kentucky Public Health Association and Director of the Jefferson County Health Department, also reported on the collaborative initiatives underway for medicine and public health. The committee also endorsed the Consensus Statement of the Physician Leadership on National Drug Policy which recommends that our national drug policy place greater emphasis on medical and public health approaches. It was noted that this policy mirrors that of KMA.

The Subcommittee on Domestic Violence meets under the auspices of the Community and Rural Health Committee and this year was active in reviewing and approving courses to meet the domestic violence CME requirements for Kentucky licensure. Physicians must attend an approved three-hour course that uses the KMA "Model Health Protocol on Abuse, Neglect and Exploitation" as its training curriculum. More than 1,500 of the 5,626 Kentucky licensed primary care physicians, both in and out of the state, have been certified by KMA either through attending one of the six KMA seminars held on domestic violence or from viewing a videotape produced by KMA to fulfill this requirement. In addition, more than 30 CME-accredited providers in Kentucky have also offered seminars and videos on domestic violence during the past two years. It was noted that after the June 30 deadline, only newly licensed physicians will need the course and availability of courses will drop dramatically.

The subcommittee heard a report from B. J. Jacobs, who staffs the Kentucky Elder Abuse Committee created by KRS 209.005. This group is working in the areas of intervention, prevention, and education. There was considerable discussion on separate definitions for abuse and neglect, access to records, and statute changes in the definition of an adult:

"Adult" means (a) A person 18 years of age or older, who because of mental or physical dysfunctioning, is unable to manage his own resources or carry out the activity of daily living or protect himself from neglect, or a hazardous or abusive situation without assistance from others, and who may be in need of protective services; or (b) A person without regard to age who is the victim of abuse or neglect inflicted by a spouse.

A request was made and approved to use parts of the KMA Model Health Care Protocol on Abuse, Neglect and Exploitation in the development of a protocol for use by various agencies providing services to the elderly.

The committee will continue to pursue these current issues and will consider additional health and safety issues in the coming year. The members of the Community and Rural Health Committee and Subcommittee on Domestic Violence would like to thank the Board of Trustees for being permitted to serve.

Baretta R. Casey, MD
Chair

RECOMMENDATIONS, REFERENCE COMMITTEE E:

Reference Committee E reviewed the Report of the Committee on Community and Rural Health. There was some testimony requesting the KMA form a joint committee with the Kentucky Public Health Association to address the new public health initiatives on medicine and public health.

Reference Committee E recommends that the Report No. 35 be adopted.

Committee on Child and School Health

The Committee on Child and School Health considers issues relating to quality medical care for Kentucky's children and advises the Board on matters relating to children's health.

Early on in the year, the committee assumed a monitoring responsibility on behalf of the Association for the Kentucky Children's Health Insurance Program (KCHIP). The federal Children's Health Insurance Program is a portion of Title XXI of the Social Security Act passed by Congress in 1997. It provides \$24 billion in funding for five years to states, beginning in 1998, providing states develop enabling legislation and the infrastructure necessary to operate the program. States have the option of conducting the CHIP program in conjunction with Medicaid or as a separate program. Part of the enabling legislation includes required state participation in the expansion of the Medicaid program. Kentucky received \$50 million in federal funds, to be matched by \$13 million from the state. The legislature appropriated the necessary monies and enacted other required provisions through SB 128 in 1998.

The media has consistently reported the progress of the KCHIP program through the year. Kentucky and all physicians in the state were fortunate in being represented directly in state activities by Thomas L. Young, MD, a Lexington pediatrician, who has served concurrently as President of the Kentucky Chapter of the American Academy of Pediatrics.

In committee discussions it was suggested early on that physicians treating KCHIP recipients should be paid at current Medicaid levels. This recommendation was forwarded to the Board of Trustees, and the principals involved in implementing KCHIP were advised of this position early in the year.

At the time this report is written, Phase II of the KCHIP program is just beginning, which expands Medicaid eligibility to children up to 150% of the federal poverty level. This phase began with a "kickoff" centered in Frankfort featuring Naomi and Ashley Judd. This phase was centered on an outreach program to publicize operations and to enroll eligible participants. Enrollment would occur at health departments, school sites, and later in physicians' offices. This phase of the program applies both to Medicaid expansion and KCHIP.

Previously, Phase I of the program, which began in July 1998, applied to children 14 to 18 years of age to 100% of the federal poverty level. Phase III of KCHIP will begin in November 1999, and will apply to children and families between 150-200% of the federal poverty level. This portion of KCHIP will be administered by the Medicaid Department and will include all Medicaid benefits, excluding non-emergency transportation and some special services.

Finally, KCHIP will be expanded to a true insurance program for children and families up to 200% of the federal poverty level who do not other-

wise qualify for Medicaid. It will be a separate insurance program with premiums, copayments, and specified benefits.

KCHIP will be operated along the same lines as the KenPAC program in non-Medicaid partnership areas with a "lock-in" for patients and capitated primary care gatekeepers. In Medicaid partnership areas, the partnerships will determine program details. Physicians will not be required to sign participating agreements for KCHIP patients, but may see them on an "as chosen" basis. Included in these provisions is the payment of physician assistants who are employed by physicians.

In other activities, the committee continued its work on the Adopt-A-Physician Program. This is a program that seeks voluntary physicians to work in collaboration with local schools as medical advisors. At the mid-point of the year, 51 schools had signed up for the program, and 109 physicians had expressed interest in participating. This project is being undertaken in cooperation with the state Department of Education. As these efforts unfold, a role will be sought for the inclusion of health departments to expand the continuum of services to school age children.

The committee reviewed and commented on regulations being proposed by the Department of Education relating to health issues. These were necessitated by a change in House statutes by the 1998 Kentucky General Assembly. Some of the requirements are that school children receive three medical examinations between grades K-12 instead of two, the elimination of the requirement for TB testing, and a new requirement for scoliosis screening. Also, the time for initial entry examination was changed from six months to one year prior to the beginning of the school year. The committee made appropriate comments on these regulations, which included a request for the insertion of the phrase "encourage sexual abstinence."

Kentucky is one of seven states receiving grant money for substance abuse prevention in children, which is being operated through a program entitled "The Governor's Substance Abuse Initiative." This program provides for the awarding of grants to local communities to conduct such programs and is receiving a good deal of focus by the Governor. In the first round of grant awards, 11 communities were funded, with a goal of 20 participating communities by the second round of grants. Substance abuse prevention programs conducted under these grants must be science-based. The committee has monitored these efforts and has indirectly participated through the Alliance representative who sits on the committee, Mrs Aroona Dave.

The issue of polio vaccinations was considered this year. At issue is a concern about the possibility of vaccine-induced polio. Presently, the state is providing vaccines to Medicaid-eligible children by way of two IVPs at two-month and four-month intervals, followed by an oral vaccine at six months. The committee intends to further monitor and attempt to influence this effort.

A debt of gratitude is owed by the committee to Ms Terry Vance with the Department of Education, Ms Jeni Bryson of the Cabinet for Health Services Division of Adult and Child Health, and to Ms Lynn Flynn of the Cabinet for Health Services for their input and assistance to the committee's efforts this year. Likewise, thanks are in order to all of the committee members for their participation, interest, and input.

Thomas H. Pinkstaff, MD
Chair

RECOMMENDATIONS, REFERENCE COMMITTEE E:

The Committee reviewed the excellent Report of the Committee on Child and School Health and would like to note the request of a KMA member that the state provide brochures about KCHIP to be distributed by private practice physicians in their offices.

Reference Committee E recommends that Report No. 37 be adopted.

Report of the Judicial Council

The KMA Judicial Council conducted no formal meetings during the past year. There were, however, inquiries from various physicians throughout the year regarding their rights and responsibilities under federal and state law, as well as the Code of Medical Ethics. KMA provided each of its members with the book *Legal Handbook for Kentucky Physicians*, which contains a discussion of various state and federal laws affecting physicians. This book is expected to aid physicians in their legal and ethical inquiries.



Three issues dominated debate and discussion throughout the year regarding physician rights and responsibilities under the Code of Medical Ethics. The first issue concerned the AMA's formation of a collective bargaining unit for employed physicians. The AMA formed this organization in response to physicians' concerns regarding managed care companies' practices and physicians' lack of bargaining power in the marketplace. While the bargaining unit will allow employed physicians to collectively bargain, it will not gain leverage by supporting strikes or any other actions that might affect patient care.

The second issue discussed during the past year concerned patient confidentiality. Maine passed sweeping legislative reform in this area in an effort to better define what information could be released and when it may be released. Unfortunately, the legislation did not work well in many instances and the state was forced to rescind the law shortly after its passage. The federal government is expected to pass similar patient confidentiality legislation this year. If such legislation is not passed, the Clinton administration will implement patient confidentiality regulations.

Another issue discussed during the past year concerned whether a physician must report someone the physician knows to be an impaired driver. The AMA debated this issue and the Council on Ethical and Judicial Affairs is expected to implement a new Ethical Opinion in the near future. Kentucky has a regulation that implies physicians may report impaired drivers, but there is still concern regarding whether such a report could lead to physician liability for breaking patient confidentiality.

The council will continue to monitor these and other issues during the coming year and physicians should stay informed so that they may properly follow their professional rights and responsibilities.

William P. VonderHaar, MD
Chair

RECOMMENDATIONS, REFERENCE COMMITTEE E:

Reference Committee E reviewed the Report of the Judicial Council and heard considerable discussion about impaired drivers.

Reference Committee E recommends that Report No. 38 be adopted.

Report of the Ad Hoc Committee on Tobacco Settlement Funds

In May, the KMA Quick Action Committee formed an ad hoc committee to make recommendations for expending Kentucky's portion of the Attorney General's tobacco settlement funds. A meeting of the Ad Hoc Committee on Tobacco Settlement Funds was held Thursday May 20, 1999, at KMA Headquarters. To assist the committee in its deliberations and to gather data, we invited Mr Todd Warnick, Kentucky's Tobacco Control Manager for Public Health; Mr Larry McCarthy, Assistant Commissioner of Medicaid; Mr Ronny Pryor, staff member of Kentucky Farm Bureau; and Ms Debbie Acker of the Association of Health Departments.

Burley tobacco is Kentucky's number one cash crop, and the tobacco industry is a major employer throughout the state. It has been estimated that Kentucky's tobacco crop grosses \$800 million to \$1 billion annually. According to the Cabinet for Health Services, Department for Public Health, Division of Epidemiology:

- Cigarette smoking is the leading preventable cause of disease and premature death in the US;
- 31.6% of Kentuckians over 18 years of age are current smokers, the highest prevalence of all the states (23.5% for all 50 states and DC);
- 23% of all deaths in Kentucky were attributed to smoking (19.5% for the nation);
- Annual health care expenditures in Kentucky directly related to smoking exceed \$1 billion;
- The number of Kentucky deaths from smoking is estimated to be approximately 7,900 annually.

SETTLEMENT SUMMARY

(1) PHASE I

The Attorneys General lawsuit and subsequent national settlement with the tobacco industry were based upon the amount of dollars paid out by states for Medicaid benefits attributed to smoking and tobacco-related ill-

nesses. The final settlement mandates that tobacco companies pay \$206 billion to 46 states over a period of 25 years. Four states settled individually. Presently, there are no strings attached to the money that will be appropriated. The 1998 Kentucky General Assembly (KGA), recognizing that a settlement was imminent, adopted legislation that requires the KGA to determine allocation of the Phase I settlement. Phase I funds are not expected to become available until July 2000. The KGA may address this issue in a called Special Session, during the 2000 Regular Session, or in a Special Session following receipt of the funds in July 2000. Kentucky will receive \$3,450,438,586.10 over a period of 25 years.

(2) PHASE II

Governor Patton also negotiated a Phase II settlement with the tobacco industry that provides Kentucky with an additional \$1.54 billion for farmers, businesses, and communities threatened as a result of the Phase I settlement. Estimated payout over 12 years is \$128 million annually. Kentucky is expected to receive Phase II settlement funds in December 1999. A committee formed by the Governor has recommended that growers and quota owners "equally" split these funds.

- (3) The national settlement calls for an additional \$1.5 billion to be set aside for nationwide anti-smoking campaigns over a 5-year period.
- (4) An additional \$250 million has been earmarked for a foundation dedicated to reducing teen smoking.

WHERE SHOULD PHASE I SETTLEMENT FUNDS GO?

- The Kentucky Farm Bureau proposes that at least 50% of Phase I funds go to agricultural purposes. Farm groups propose that Kentucky's portion of the settlement finance farm transitional programs from a tobacco-based economy to alternative agricultural products and services. Additional funds would be targeted to assist rural agricultural communities and businesses affected by the settlement.
- The Kentucky Action group, of which KMA was a founding member, seeks \$19 million annually for programs to reduce teen smoking.
- The Kentucky Health Department Association recommends that a portion of the settlement fund effective, public health, tobacco prevention programs, which are adequately funded and sustainable over time.
- Governor Patton recommends providing funds for early childhood development and health care.
- Speaker of the House Jody Richards and Senate President Larry Saunders propose using the bulk of Phase I money for transition from tobacco to non-tobacco crops.
- Senate Minority Leader David Williams, expressing considerable sentiment within members of the Kentucky General Assembly, proposes dumping the money into the General Fund.
- Senator Dick Roeding has proposed establishing a "high risk pool" for the uninsured with settlement funds.
- County and state officials, particularly those in "high growth counties," recommend that a significant amount of settlement funds should go to "infrastructure," particularly streets and highways.

We communicated with surrounding states regarding any activities they may have undertaken in this area. Several took a "hands off" approach, while some states worked with various groups to develop a consensus. We were particularly interested in the other tobacco states, especially North Carolina and Virginia. Virginia took a "hands off" approach, and according to reports, only 10% of the settlement funds go to health or medical education or services. North Carolina Medical Society joined with a group of health and medical groups to recommend that health issues be allotted 50% of the funds. However, the General Assembly allocated only 25% to health issues.

CONGRESS/WHITE HOUSE/GOVERNORS

The Phase I settlement was based on state Medicaid expenditures attributed to smoking and related illnesses. The federal government attempted to intervene and reclaim "Medicaid matching funds" supplied to individual states. In Kentucky's case, the federal government provides Medicaid matching funds on a 3-1 basis. The nation's Governors lobbied to assure that settlement funds would go "unrestricted" to state treasuries. Some Congressmen and the Administration wanted assurance that a percentage of the tobacco settlement would fund health care and related "smoking cessation programs." The recent Session of the US Congress adopted legislation that forbids the federal government from reclaiming any of these funds.

KMA HOUSE OF DELEGATES POSITION ON SETTLEMENT FUNDS

The national settlement occurred on November 16, 1998. Therefore, the September 1998 House of Delegates did not have adequate information to directly or specifically address allocating Phase I settlement funds. However, in the past, the House of Delegates has addressed this issue in a general way.

In 1997, the KMA House of Delegates in Resolution 97-136 stated:

"Resolved that any settlement should include provisions that protect tobacco farmers and workers by funding programs which finance transition from growing tobacco to food or other farming products or services."

Previously, the House **"supported increases in the tax on tobacco in order to lower the number of new teenage smokers. Funds raised through the increased tobacco tax should be used to fund health care in Kentucky, and to fund the development of agricultural alternatives to growing and processing of tobacco and tobacco products."** (KMA legislative handbook)

RECOMMENDATIONS

The Ad Hoc Committee on Tobacco Settlement Funds reviewed the following options.

- Agriculture transition
- Programs to reduce teen smoking
- Adult smoking cessation and education programs
- Medicaid expansion
- Indigent care
- High-risk pool or additional funding for the Guaranteed Access Program (GAP insures Kentucky's "uninsurable.")
- Medical research for cancer and other smoking-related illnesses
- Public health initiatives

After researching and reviewing various alternatives for expending the tobacco settlement funds, the KMA Ad Hoc Committee on Tobacco Settlement funds recommends the following:

- 50% (\$64 million annually) to expand Medicaid services for poor Kentuckians. (The Kentucky Medicaid program receives 3 for 1 matching dollars from the federal government.)
- 20% (\$25.6 million annually) to transition Kentucky agriculture from a tobacco-based economy to alternative crops and services.
- 20% (\$25.6 million annually) to early childhood development and children's health and prevention services.
- 5% (\$6.4 million annually) to provide research grants to Kentucky's medical schools for tobacco-related illnesses.
- 5% (\$6.4 million annually) to reduce teen smoking, fund smoking cessation and education programs. Funds for this purpose should be allocated to county and regional health departments for development and implementation.

According to the latest reports, settlement funds are expected to be received in June 2000. In all probability, decisions may come at a Special Session of the Kentucky General Assembly in 2000. While the recommendations of this ad hoc committee will be lumped with hundreds of other group and individual recommendations, the committee report will assist the Association leadership in meetings with the Governor, his Administration, and leadership and members of the Kentucky General Assembly.

I sincerely appreciate the assistance members of the committee provided to this Association and the report of this committee. Special thanks go to Kentucky Farm Bureau, Cabinet for Health Services, Kentucky Association of Health Departments, and the office of the Commissioner of Health for their presentations and background information.

Harry W. Carloss, MD
Chair

RECOMMENDATIONS, REFERENCE COMMITTEE E:

Reference Committee E considered the Report of the Ad Hoc Committee on Tobacco Settlement Funds. This carefully reasoned report considers many important priorities. The Committee heard extensive testimony from members of the KMA Board, members of the Ad Hoc Committee itself, representatives from the public health community, representatives from non-profit health agencies, and from many interested physicians. The Committee commends the Ad Hoc Committee for its excellent work.

After careful consideration of background information, as well as testimony, Reference Committee E recommends that the Ad Hoc Committee report recommendations be amended by changing percentage allocations as follows:

- 50% (\$64 million annually) to expand Medicaid services for poor Kentuckians. (The Kentucky Medicaid program receives 3 for 1 matching dollars from the federal government.)
- ~~20%~~ 15% (\$25.6 ~~\$19.2~~ million annually) to transition Kentucky agriculture from a tobacco-based economy to alternative crops and services.
- ~~20%~~ 15% (\$25.6 ~~\$19.2~~ million annually) to early childhood development and children's health and prevention services.
- 5% (\$6.4 million annually) to provide research grants to Kentucky's medical schools for tobacco-related illnesses.
- ~~5%~~ 15% (\$6.4 ~~\$19.2~~ million annually) to reduce teen smoking, fund smoking cessation and education programs. ~~Funds for this purpose should be allocated to county and regional health departments for development and implementation.~~

The Reference Committee recommends that the Ad Hoc Committee report and its recommendations be adopted as amended.

The Recommendations of the Report of the Ad Hoc Committee on Tobacco Settlement Funds were further revised on the floor of the House by deleting the dollar amounts while retaining percentages. The Recommendations were adopted as amended by Reference Committee E and from the floor of the House.

The report's recommendations, as amended and approved by the House of Delegates, would read as follows:

- 50% to expand Medicaid services for poor Kentuckians. (The Kentucky Medicaid program receives 3 for 1 matching dollars from the federal government.)
- 15% to transition Kentucky agriculture from a tobacco-based economy to alternative crops and services.
- 15% to early childhood development and children's health and prevention services.
- 5% to provide research grants to Kentucky's medical schools for tobacco-related illnesses.
- 15% to reduce teen smoking, fund smoking cessation and education programs.

RESOLUTION 99-118**Tobacco Settlement Allocation
Jefferson County Medical Society**

WHEREAS, cigarette smoking kills more Americans each year than alcohol, car accidents, homicides, suicides, illegal drugs, fires and AIDS combined; and

WHEREAS, approximately 7,900 people in Kentucky die from smoking each year, and 47% of Kentucky high school students smoke cigarettes (the highest rate in the nation); and

WHEREAS, if current trends continue, 87,000 Kentucky children eventually will die from smoking, and Kentucky's annual Medicaid costs directly related to smoking are estimated to total \$201 million; and

WHEREAS, the American Medical Association House of Delegates in June 1999 reaffirmed its commitment to long-standing policies that states should use tobacco settlement monies for legitimate public health purposes, education and prevention of nicotine addiction, treatment of diseases related to nicotine addiction and tobacco use, and improved access to medical services; and

WHEREAS, the Kentucky Medical Association believes that a comprehensive plan, focused primarily on youth prevention and cessation, will have the effect over time of reducing the burden of tobacco-related disease in Kentucky; now, therefore, be it

RESOLVED, that the Kentucky Medical Association exhorts the Kentucky General Assembly to enact legislation that allocates substantial funds from the tobacco suit Master Settlement Agreement (MSA) for comprehensive tobacco prevention and cessation programs including research, education, prevention, and treatment of nicotine addiction in youth and pregnant women; and be it further

RESOLVED, that the KMA join other similarly interested parties throughout Kentucky in urging the General Assembly that a minimum of \$21,205,391 be allocated from the MSA for the above-stated purposes, in accordance with recommendations from the Centers for Disease Control and Prevention, as described in "OUR CHILDREN, OUR FUTURE: Blueprint for a Comprehensive Youth Tobacco Prevention Program in Kentucky"; and be it further



RESOLVED, that monies paid to the state of Kentucky from the MSA be used to increase the budget for on-farm diversification and agricultural infrastructure to assist farmers who wish to reduce their dependence on tobacco.

RECOMMENDATIONS, REFERENCE COMMITTEE E:

Reference Committee E heard considerable testimony about Resolution 118 — Tobacco Settlement Allocation, submitted by the Jefferson County Medical Society.

Reference Committee E recommends that the second "RESOLVED" be amended as follows:

RESOLVED, that the KMA join other similarly interested parties throughout Kentucky in urging the General Assembly that a minimum ~~\$21,205,294~~ 15% of funds be allocated from the MSA for the above-stated purposes, in accordance with recommendations from the Centers for Disease Control and Prevention, as described in "OUR CHILDREN, OUR FUTURE: Blueprint for a Comprehensive Youth Tobacco Prevention Program in Kentucky"; and be it further

Reference Committee E recommends adoption of Resolution 118 as amended.

RESOLUTION 99-109

Health Education Curricula

Thomas L. Young, MD, President,
Kentucky Chapter, American Academy of Pediatrics

WHEREAS, there is a strong, proven relationship between comprehensive school health programs and academic outcomes; and

WHEREAS, according to the American Cancer Society, students have never before faced more severe health and social problems; and

WHEREAS, these theories are borne out by the incidence of high-risk behaviors by Kentucky's school age children as documented by the Kentucky Department of Education Youth Risk Behavior Report; and

WHEREAS, adequate school health education curricula can provide longitudinal exposure to training in conflict resolution, decision making and consequences, and self-esteem factors; and

WHEREAS, a reduction in intentional injuries (abuse, homicide, suicide) and high risk behaviors (drug and alcohol abuse, dietary, physical and sexual behaviors) can be shown to result from adequate school health education; and

WHEREAS, health education currently has a low-rank weight in scoring for Kentucky Education Reform Act (KERA) tests and consequently has low curriculum priority; now, therefore, be it

RESOLVED, that KMA use all appropriate means to encourage the state Board of Education to increase the KERA test score weight for health education so that local school authorities will increase health education in school curricula.

RECOMMENDATIONS, REFERENCE COMMITTEE E:

Reference Committee E reviewed Resolution 109, Health Education Curricula, submitted by Thomas L. Young, MD, President, Kentucky Chapter, American Academy of Pediatrics. Reference Committee E recommends that Resolution 109 be adopted.

RESOLUTION 99-111

Repeal State Mandated Procedural Counseling Jefferson County Medical Society

WHEREAS, recurring bills in Congress and in many state legislatures would impose procedure-specific requirements for informed consent and special waiting periods for certain medical procedures; and

WHEREAS, such waiting periods and informed consent requirements often are not medically indicated and never are appropriate areas for codification in law; and

WHEREAS, these waiting periods and consent requirements can create legal and ethical dilemmas for physicians and inconvenience or emotional trauma for patients; and

WHEREAS, the American Medical Association took an identical position on the subject in Resolution 226 at the AMA 1999 Annual meeting; now, therefore, be it

RESOLVED, that the Kentucky Medical Association oppose legislative measures that would impose procedure-specific requirements for informed

consent or a waiting period for any legal medical procedure, and seek the repeal of existing statutes that do so.

RECOMMENDATIONS, REFERENCE COMMITTEE E:

Reference Committee E reviewed Resolution 111, Repeal State Mandated Procedural Counseling, submitted by the Jefferson County Medical Society. The Committee considered this resolution at length but heard little testimony.

Reference Committee E recommends that Resolution 111 be referred to the Board of Trustees.

A motion was made from the floor of the House, seconded and carried to Table this issue.

RESOLUTION 99-114

Expand Medical Practice Act to Hold that Medical Review is the Practice of Medicine Jefferson County Medical Society

WHEREAS, the House of Delegates adopted Resolution 97-119, entitled "Health Carriers' and Managed Care Organizations' Tort Liability," which held that:

- the medical directors, nurses, and other employees of insurance companies, health maintenance organizations, and managed care networks are determining whether a treatment or procedure recommended by the patient's attending physician is medically necessary; and further
- that medical directors of insurance companies, health maintenance organizations, and managed care networks serving patients in Kentucky be required to be licensed by the Commonwealth of Kentucky and to fall under jurisdiction of the Kentucky Board of Medical Licensure; and further
- that the health carriers and managed care organizations and their employees who make decisions which result in patient injury should be held legally responsible for their decisions; and

WHEREAS, it was resolved by 97-119 that the Kentucky Medical Association would further these efforts through its interactions with the Kentucky Board of Medical Licensure, available legislative venues, and the American Medical Association; and

WHEREAS, patient care and physician decision-making continue to suffer from the above-stated practices; now, therefore, be it

RESOLVED, that the Kentucky Medical Association reaffirm its support for Resolution 97-119, and its belief that medical review constitutes the practice of medicine and that, as such, medical review falls under the jurisdiction of the Kentucky Board of Medical Licensure; and be it further

RESOLVED, that the Kentucky Medical Association work with the Kentucky Board of Medical Licensure and the Kentucky General Assembly, as needed, to ensure that medical review be included and identified in the Medical Practice Act as the practice of medicine.

RECOMMENDATIONS, REFERENCE COMMITTEE E:

Reference Committee E considered Resolution 114 — Expand Medical Practice Act to Hold that Medical Review is the Practice of Medicine, submitted by the Jefferson County Medical Society, and heard testimony in support. The Reference Committee also heard testimony from a physician indicating that the Attorney General in Ohio was not receptive to this concept and urging KMA to work with our State Legislature instead of the Attorney General.

Reference Committee E recommends adoption of Resolution 114.

RESOLUTION 99-122

Infection Control in the Cosmetic Industry Jefferson County Medical Society

WHEREAS, there appears to be little, if any, state health regulation of cosmetologists and the procedures they perform; and

WHEREAS, such procedures frequently result in piercing or cutting of the skin, either intentionally or by accident, resulting in the potential exposure of blood borne pathogens to both the client and the provider of the services; and

WHEREAS, informal reports indicate that at least some of these service providers do not use or understand the need for appropriate sterile procedures and/or infection control; and

WHEREAS, there exists the potential for public harm due to this lack of education and regulation; now, therefore, be it

RESOLVED, that the Kentucky Medical Association, through its Rural and Community Health Committee, study this issue and pursue the enactment of legislation to enact infection control policies and procedures in the cosmetic industry if indicated.

RECOMMENDATIONS, REFERENCE COMMITTEE E:

Reference Committee E considered Resolution 122 — Infection Control in the Cosmetic Industry, submitted by the Jefferson County Medical Society. Considerable enlightening and interesting testimony on this issue was heard.

Reference Committee E recommends that Resolution 122 be referred to the Board of Trustees.

RESOLUTION 99-123

Kentucky State Licensure Requirement for International Medical Graduates

Rajesh K. Sheth, MD, Kentucky Indiana Association of Physicians from India and American College of International Physicians

WHEREAS, there is a disparity in license requirements between physicians from American medical schools and those from international medical schools; and

WHEREAS, American medical graduates may be licensed to practice medicine in Kentucky after one year of residency training, but international medical graduates may only be licensed to practice in Kentucky after three years of residency training; and

WHEREAS, KMA should be aware that now both domestic and international medical graduates take the same USMLE test to qualify for medical residency training; now, therefore, be it

RESOLVED, that the KMA pursue the enactment of legislation to eliminate the three-year residency training requirement for Kentucky medical licensure of international medical graduates.

RECOMMENDATIONS, REFERENCE COMMITTEE E:

Reference Committee E heard extensive testimony from a variety of individuals and entities about Resolution 123 — Kentucky State Licensure Requirement for International Medical Graduates, submitted by Rajesh K. Sheth, MD, Kentucky Indiana Association of Physicians from India and American College of International Physicians. After considerable discussion, the Reference Committee recommends amendment of the RESOLVED in Resolution 123 as follows:

RESOLVED, that the KMA pursue the enactment of legislation to ~~eliminate the three-year residency training requirement for Kentucky medical licensure of international medical graduates.~~ **require that all physicians, be they United States or international medical graduates, complete the same training requirement for medical licensure.**

Reference Committee E recommends adoption of Resolution 123 as amended.

An amendment was offered from the floor of the House to insert "residency" between "same" and "training" in the final line of the Resolved. Resolution 123 was adopted as amended by Reference Committee E and on the floor of the House.

Mr Speaker, Reference Committee E recommends the adoption of the report of Reference Committee E as a whole, as amended.

Mr Speaker, I would like to thank the other members of this committee—Jane R. Bramham, MD, Bowling Green; James E. Redmon, MD, Louisville; Jeffrey B. Richardson, MD, Elizabethtown; James S. Shockey, MD, Pikeville, and Scott A. Watkins, Jr, MD, Henderson—for their time and thoughtful consideration of the issues referred to the reference committee. The Chair would also like to thank Jean Wayne for her support and assistance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE E
Barbara A. Phillips, MD, Lexington, Chair
Jane R. Bramham, MD, Bowling Green
James E. Redmon, MD, Louisville
Jeffrey B. Richardson, MD, Elizabethtown
James S. Shockey, MD, Pikeville
Scott A. Watkins, Jr, MD, Henderson

A request was made from the floor that, in order to facilitate consideration of issues, the Rules Committee consider adding to the Consent Calendar noncontroversial items to be adopted. [NOTE: This matter will be

referred to the Rules Committee.]

Dr Cooper then made a motion on behalf of the Board to appoint John W. Collins, MD, Lexington, to the KMA Judicial Council. Dr Collins was nominated to replace Charles R. Sachatello, MD, Lexington, whose term had expired. The motion was seconded, and carried.

Tellers C. Kenneth Peters, MD, Jeffersontown; Edward L. Scofield, MD, Louisville; and John D. Stewart, II, MD, Lexington, were thanked for their efforts.

Election of Officers

Barbara Phillips, MD, Chair of the Nominating Committee, presented the slate of nominees for offices, as follows:

President-Elect William P. VonderHaar, MD, Louisville

A motion was made, seconded and carried to accept the nomination, and Dr VonderHaar was escorted to the podium by Past Presidents C. Kenneth Peters, MD, and Robert R. Goodin, MD. The following nominees were also elected:

Vice President (2000)	Andrew R. Pulito, MD, Lexington
Speaker-Treasurer (2002)	Linda H. Gleis, MD, Louisville
Delegate to the AMA (Jan 1, 2000-Dec 31, 2001)	J. Gregory Cooper, MD, Cynthiana
Delegate to the AMA (Jan 1, 2000-Dec 31, 2001)	Ardis D. Hoven, MD, Lexington
Alternate Delegate to the AMA (Jan 1, 1999-Dec 31, 2000)	Don R. Stephens, MD, Cynthiana
Alternate Delegate to the AMA (Jan 1, 1999-Dec 31, 2000)	Baretta R. Casey, MD, Pikeville

Dr Phillips then submitted the following nominations for the offices of Trustees and Alternate Trustees on behalf of the Trustee District nominating committees, and each was elected by acclamation:

2nd District Trustee	Don R. Neel, MD, Owensboro
2nd District Alternate	David A. Watkins, MD, Henderson
5th District Trustee	Daniel W. Varga, MD, Louisville
5th District Alternate	Susan M. Berberich, MD, Louisville
6th District Trustee	James F. Beattie, MD, Bowling Green
6th District Alternate	J. Michael Pulliam, MD, Franklin
8th District Trustee	Thomas E. Bunnell, MD, Crestview Hills
8th District Alternate	Donald J. Swikert, MD, Edgewood
11th District Trustee	Richard A. Stone, MD, Richmond
11th District Alternate	Suvas G. Desai, MD, Richmond
15th District Trustee	Meredith J. Evans, MD, Middlesboro
15th District Alternate	Sandford L. Weiler, MD, Harlan

Election of 2000 Nominating Committee

The following physicians were elected by the House of Delegates to serve as the 2000 KMA Nominating Committee:

P. Bruce Barton, MD, Corbin (Whitley), Chair
W. Lisle Dalton, MD, Lexington (Fayette)
James P. Farrell, MD, Crestview Hills (Kenton)
Linda Mumford, MD, Owensboro (Daviess)
Jeffrey B. Richardson, MD, Elizabethtown (Hardin)

A request was made from the floor that the Board of Trustees report back to the House on implementation of actions taken at this meeting. [NOTE: An addendum, "Summary of Implementation of Actions," is attached each year to the Report of the Chair, Board of Trustees, and appears in the Annual Reports Book distributed to delegates.]

Newly installed KMA President Harry W. Carloss, MD, was called to the podium and made some brief remarks.

Speaker McClellan adjourned the 1999 Session of the KMA House of Delegates at 10:40 PM.

1999-2000 KMA COMMITTEES

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 Donald C. Barton, MD, Corbin
 Wally O. Montgomery, MD, Paducah
 Donald J. Swikert, MD, Florence
 Wm. P. VonderHaar, MD, Louisville

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 Susan Galandiuk, MD, Louisville
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 David Goebel, MD, Ashland
 George H. Goldsmith, MD, Louisville
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 Daniel E. Kenady, MD, Lexington
 Patrick McGrath, MD, Lexington
 Kelly M. McMasters, MD, Louisville
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 Eric Davis, Louisville (student)
 Ex-Officio:
 Martha Hinton, Paducah
 Wayne B. Miller, Louisville, American Cancer Society
 Tom Tucker, PhD, Lexington, UK Markey Cancer Center
 Connie Sorrell, Kentucky Cancer Center

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 Paul R. Smith, MD, London
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 David A. Watkins, MD, Henderson
 James E. Wheeler, MD, Madisonville (resident)
 Maria Smith, Louisville (student)
 Nitu Dhaliwal, Louisville, (student)

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 Terry Vance, KY Department of Education

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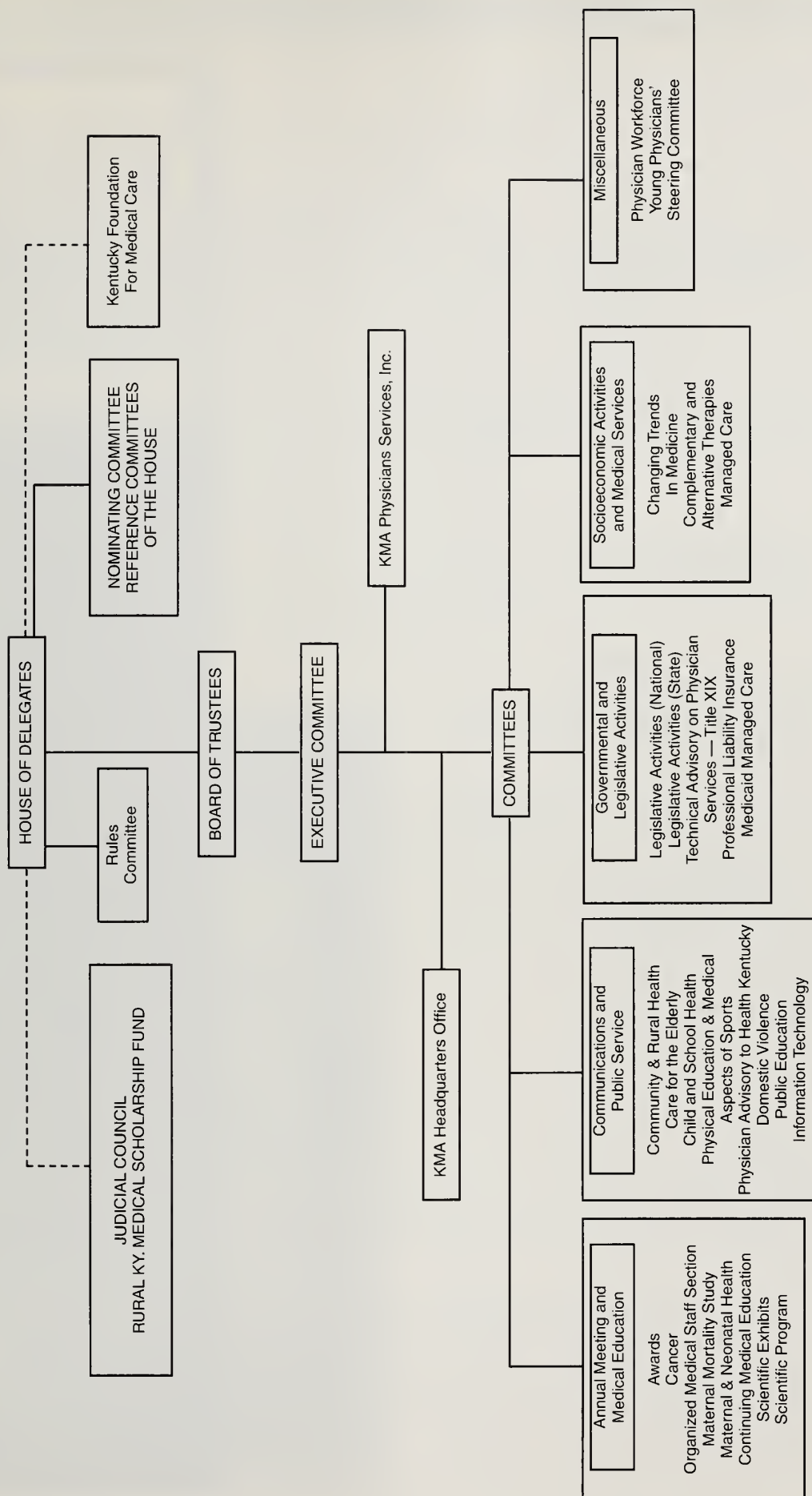
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3. Filing Date: 9/30/99

4. Issue Frequency: Monthly

5. Number of Issues Published Annually: 12

6. Annual Subscription Price: \$35.00

7. Complete Mailing Address of Known Office of Publication (Not printer) (Street, city, county, state, and ZIP+4): 4965 US Hwy 42, Suite 2000, Louisville, KY 40222

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AMERICAN MEDICAL ASSOCIATION . . .	312-464-5000 or 800-262-3211
AMPAC	202-789-7434
KEMPAC	502-426-6200
Associations	
American Medical Association Alliance . .	312-464-4470
Kentucky Academy Family Practice . . .	502-451-0370
Kentucky Hospital Association	502-426-6220
Kentucky Medical Association Alliance . .	502-426-6200
Kentucky Medical Insurance Agency . . .	502-339-5750
Kentucky Medical Insurance Company . .	502-339-5700
Kentucky Physician's Care	800-633-8100
Kentucky Rural Medical	
Scholarship Fund	502-426-6200
Medical Societies	
Daviess County Medical Society	502-688-3165
Fayette County Medical Society	606-278-0569
Jefferson County Medical Society	502-589-2001
Northern Kentucky Medical Society . . .	606-578-6802
Medical School Deans	
University of Kentucky	606-323-5567
University of Louisville	502-852-5184
Medicare	502-425-7776
Medicaid	502-564-4321
Social Security Administration	800-772-1213
State Government	
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Governor's Office	502-564-2611
Kentucky Board of Medical Licensure . .	502-429-8046
Legislative Research Commission	502-564-8100
Secretary Cabinet for Health Services . .	502-564-7130

NOTE: AREA CODE CHANGES

The entire state of Kentucky is in the process of changing Area Codes. Numbers listed in this Handbook were in effect as of the date of publication. We apologize for any inconvenience you may encounter as the Area Codes are changed.



2000

FOREWORD

The Kentucky Medical Association and the American Medical Association represent you on a daily basis. The KMA has an active physical presence throughout the year in Frankfort. KMA officers and staff work with AMA and Kentucky's congressional delegation in Washington.

However, the major lobbying effort rests with the KMA Key Contacts and physician constituents of the members of Congress and the Kentucky General Assembly. The most important contribution you can make is to write a personal letter to your elected representatives outlining your personal concerns, particularly as they relate to your patients. Follow up that letter with a phone call. Then urge your fellow physicians to do the same.

If you have questions, don't hesitate to contact your Trustee, KMA officers, or staff. We are interested in your views and need your full support.



Wally O. Montgomery, MD
Chair, Committee on
State Legislative Activities



Donald C. Barton, MD
Chair, National Legislative
Activities Committee

The Kentucky Medical Association gratefully acknowledges the Legislative Research Commission for its cooperation in providing photographs and much of the information in this publication.



2000

You May Contact Your Legislator By Phone

When the General Assembly is in session, you may call your legislators in Frankfort at the following numbers:

Legislative Message Line1-800-372-7181
Bill Status Line1-800-809-0200
Meeting Information Line1-800-633-9650
Citizen Contact Line1-800-592-4399
Legislative Offices 502-564-8100

KMA Officials

If you have questions during the session, don't hesitate to contact your Trustee, KMA Officers, or staff. The following numbers may be used:

Wally O. Montgomery, MD502-441-4300
Chair, Committee on State Legislative Activities	
Preston P. Nunnelley, MD606-278-0363
Vice Chair, Committee on State Legislative Activities	
KMA Headquarters502-426-6200
William T. Applegate (Executive Vice President)	
Robert E. Klinglesmith (Director, Professional Relations)	
Patrick T. Padgett (Director, Socioeconomic Affairs & Staff Counsel)	
Diane M. Maxey (Director, Member Services)	

KMA Lobbyists (Home Phone Numbers)

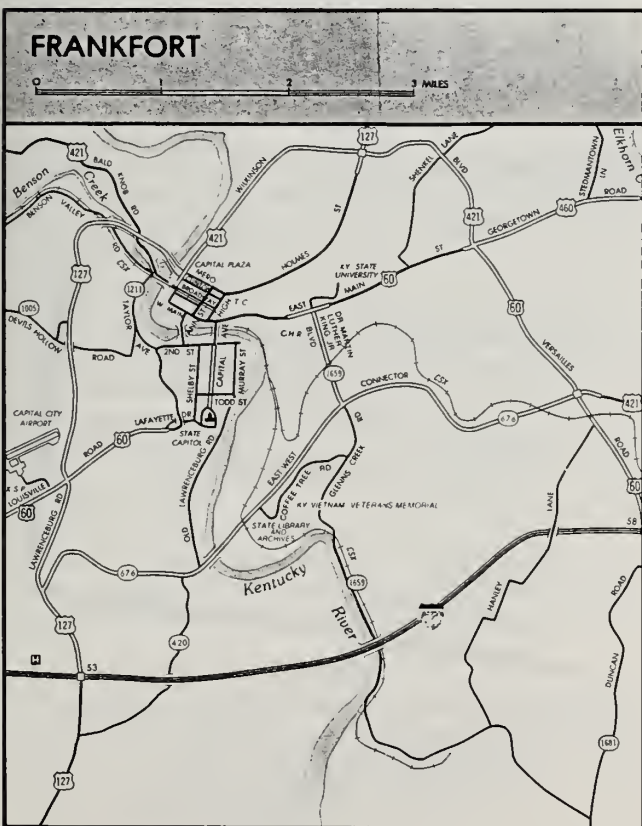
Don R. Chasteen, Louisville502-429-5126
John P. Cooper, Georgetown502-868-9128
William E. Doll, Jr, Frankfort502-223-3150
Marty E. White, Louisville502-429-8076

"Every person owes part of his time and money to the business or industry in which he is engaged. No person has a moral right to withhold support from an organization that is striving to improve conditions within his sphere."

— TEDDY ROOSEVELT

Coming to Frankfort?

1. Contact your legislator and schedule a visit.
2. Contact KMA and arrange for a briefing by a KMA lobbyist prior to your legislative visit.
3. If your legislator is on a health-related committee, visit on a day the committee meets. You'll get a real perspective of their activities.
4. Time your visit — visit early and discuss important issues prior to a vote.
5. Keep up during the Session — drop a note thanking your legislators — reminding them of your position.
6. After the Session — remember their record on election day.





2000

Duties of Officials

What are the duties of state legislators? Here are job descriptions for state senators and representatives:

There are 38 senators, each represent about 100,000 people and serve four-year terms; half the Senate is elected every two years. Each of the 100 representatives represent an average of about 38,000 people and serve two-year terms. The Senate and House of Representatives, which together are called the General Assembly, have a 60-day regular session in even-numbered years and a short organizational session in odd-numbered years, and can be called into special session by the Governor. Senators and representatives propose, consider, and vote on legislation dealing with topics such as the budget, education, health care, crime, the environment, and abortion. They vote whether to put constitutional amendments on the ballot and can review regulations issued by state agencies and state contracts.

Writing Effective Letters to Legislators

In communicating your ideas and positions on issues with legislators, writing a letter is the most effective. The following tips may help in presenting your views.

1. Use personal stationery.
2. Indicate which bill or issue you are addressing.
3. Get to the point! Do you support or oppose the bill.
4. Provide concrete, credible information on the legislation's impact.
5. Act promptly. Good letters arriving after a vote are useless.
6. Keep letters short. One-page letters have more impact than long ones.
7. If legislators do what you ask, send a thank you letter.

Letters can be mailed to the following address:

The Honorable (legislator's name)
Kentucky State Senate **OR**
Kentucky House of Representatives
Frankfort, KY 40601

Eight Major Mistakes in Dealing With Legislators

1. Assume each legislator is a walking encyclopedia on every pending issue.

During a normal session of the General Assembly, approximately 1500 different bills are introduced with about one third becoming law. That's a lot of legislation to read, review and remember. It's virtually impossible for every legislator to know every bill, chapter and verse. Individual legislators are most familiar with three types of bills — those they personally sponsor, those that come before committees on which they serve, and those that someone in their district has urged them to either support or oppose.

2. Expect a commitment on the spot.

Most legislators are thoughtful, deliberate types, who make a point to seek out all sides of a particular issue before taking a position. Remember that a good politician generally checks out the water's depth before diving.

3. Come armed without the facts.

Smoke and mirrors won't do the job in winning a legislator over. You must demonstrate through tangible evidence supported by facts that a particular action is both desirable and justifiable — and the ultimate burden of proof is on you.

4. Forget there's always another side to the issue.

Each state representative has an average of 37,280 constituents; each state senator has an average of 98,105. You can be sure that there's at least one constituent, if not more, who has a different position on an issue and, just like you, expects to have his or her voice heard. As one veteran officeholder is fond of saying, "Some of my friends are for this bill, some are against — and I'm sticking with my friends!"

5. Run down the opposition.

Name-calling or derogatory remarks don't win friends and influence legislation. If your issue can't stand on its own merit, then your cause is already lost. Besides, your legislator's brother-in-law might be a key member of the group that's on the other side of the fence!

6. Burn your bridges when you don't win.

Working with the legislators is an investment that may not pay off immediately. Don't burn your bridges if results aren't immediately forthcoming.

7. Fail to say thank you.

Even though meeting with constituents comes with the territory for legislators, it's still an act that should be acknowledged. A thank-you note for taking the time to meet with you is always in order.

8. Leave never to be heard from again.

One phone call or visit isn't enough. That means keeping in touch to let the legislator know that your interest is not a passing fancy. Stay on top of developments relating to your issue so that when new and relevant information becomes available, you can pass it along.



2000

ONLINE TRACKING OF LEGISLATION

Citizens of Kentucky are fortunate to have one of the finest online legislative tracking services in the nation. Whether it's a schedule of legislative meetings or the full text of a bill you are after, Kentucky's Legislative Research Commission (LRC) provides the information through its web site located at:

www.lrc.state.ky.us/home.htm

When you type this address in and press enter, the web browser you are using will take you directly to the Kentucky Legislature home page.

Add to Your Favorites

We encourage physicians to include this as one of their "Favorites" by clicking on the Favorites icon (if you use Windows 95) located at the top of your web browser. When you click on the Favorites icon a window should pop down and the option to "Add to Favorites" should appear. Click on that icon and the Kentucky Legislature Home Page will become a site you can refer to easily by appearing on the "Favorites" menu every time you click on it.

Search for Specific Legislation

On the Kentucky Legislature Home Page, there are several options from which to choose. To search for a specific piece of legislation, follow the instructions below:

- Step 1:** Click on the "Legislative Record" icon—A screen will appear with the title "Legislative Record Online"
- Step 2:** Determine whether you are searching for a bill or resolution—Bills begin with either HB or SB and resolutions begin with HR or SR, for example HB123 (House Bill 123) or SR1 (Senate Resolution 1)
- Step 3:** Click on "House" or "Senate" (shaded in blue) for the bill or resolution you are searching for—A screen will appear with rows of numbers
- Step 4:** Double click on the number of the bill or resolution you are searching for—A screen will appear for the bill or resolution that identifies the bill number, its sponsors, a brief synopsis and its progression through the legislature

Step 5: Double click on the bill number (shaded in blue) to obtain the full text of the bill

Other Useful Information on the Site

- Weekly legislative calendars
- Lists of legislators
 - their contact information
 - the counties they represent
 - the committees they serve on
- Visitor information

For more information about the Kentucky Legislature Web Site call (502) 564-8100 or KMA at (502) 426-6200.

**LEGISLATIVE INFORMATION
ON KMA WEBSITE
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**GO TO: www.kyma.org and
CLICK ON: Legislative**



US/STATE LEGISLATORS

- Identify (by entering your zipcode)
- Access (instantly by e-mail)
- State & National Legislative Alerts
- Weekly Legislative Bulletins during 2000 General Assembly
- Link to LRC Home Page



KMA LEGISLATIVE POLICY



HOW A BILL BECOMES LAW

Only members of the General Assembly can introduce legislation. The Constitution requires that a bill relate to only one subject, which must be stated in the title. Bills that don't adhere to this rule have been ruled unconstitutional. A committee or any legislator may propose amendments, but bills can be amended only by a vote of the House or Senate. If changes alter a bill significantly in committee, these changes may be rolled into the bill as one amendment called the Committee Substitute. All bills are introduced by delivering them to the House or Senate Clerk, after which the Committee on Committees refers them to an appropriate standing committee.

INTRODUCTION AND COMMITTEE REFERRAL

- A bill may be introduced in the House or Senate.
- Each bill is assigned a number, read by title only and sponsor, and referred to a standing committee by the Committee on Committees.

COMMITTEE CONSIDERATION

- A bill may be reported out of committee with one of the following reports: favorable with amendments, favorable with committee substitute, unfavorable or, in the Senate, without option.
- A committee can essentially kill a bill by failing to act on it.

FIRST READING

- When a committee reports a bill favorably, the bill has its first reading and is placed in the calendar for the following day.

SECOND READING: TO RULES

- The bill is read by title a second time and sent to the Rules Committee.
- The Rules Committee may send the bill back to a committee or place it in the Orders of the Day for a specific day.

THIRD READING AND PASSAGE

- Majority Floor Leader initiates floor debate on a bill.
- Following debate and amendments, a final vote on the bill is taken.
- To pass, a bill must be approved by at least two-fifths of the members of the chamber (40 Representatives or 16 Senators) and a majority of the members present and voting.
- If a bill contains an appropriation or emergency clause, it must be approved by a majority of the members elected to each house (51 Representatives–20 Senators).
- Proposed amendments to the Kentucky Constitution require a three-fifth vote of each chamber (60 Representatives–23 Senators).

SECOND CHAMBER CONSIDERATION

- If a bill passes in one house, it is sent to the other chamber

where it follows the same procedure. Both chambers must agree on the final form of each bill. If either house fails to concur in amendments made by the other, a Conference Committee of Senators and Representatives must reconcile the difference. Compromises agreed to by Conference Committees are then subject to approval by both Houses.

ENROLLMENT

- The bill is signed by the presiding member of each House and sent to the Governor.

GOVERNOR'S ACTION

- The Governor may sign a bill, permit it to become law without signing it, or veto it.
- The veto may be overridden by a majority of the members (51 Representatives–20 Senators)
- The Governor has 10 days (excluding Sundays) to act on a bill after it has been received.

BECOMING A LAW

- The Constitution specifies that an Act becomes law 90 days after the General Assembly adjourns, unless it contains a late effective date or an emergency clause.
- Bills with an emergency clause must be approved by a constitutional majority (half the members plus one), and become effective immediately upon approval of the Governor.

RESOLUTIONS

Besides bills, the Legislature may express its feelings in Simple, Concurrent, or Joint Resolutions.

- Simple Resolutions require action by only one House. They are used to handle procedure, organization, or to express the sense of the chamber on a particular matter. Frequently, the House or Senate passes a Simple Resolution to adjourn in honor or in memory of an individual.
- Concurrent Resolutions adopted by both Houses are used to mandate legislative studies and send messages to other branches of government. They are sent to the Governor, but do not have the force of law.
- Joint Resolutions are used to ratify amendments to the US Constitution, to direct an executive branch agency to conduct a study, or to enact a temporary law. Joint Resolutions have the force of law, must pass both chambers, be sent to the Governor, and filed with the Secretary of State.



HOW A REGULATION IS IMPLEMENTED

(1) Notice of Intent to Promulgate

Government Agency (ie, Department of Medicaid) files a Notice of Intent to promulgate (develop a regulation on a specific topic). The notice is printed in the *Administrative Register of Kentucky*, a publication published monthly by the Legislative Research Commission. Upon request, a public hearing may be held on the "notice of intent to file."

(2) Regulation Printed in the *Administrative Register*

Within 45 days, the complete language of the proposed regulation is printed in the *Administrative Register*. Notification of a public hearing on the proposed regulation is also published.

(3) Administrative Regulation Review by Legislative Subcommittee

The seven member Administrative Regulation Review Subcommittee (ARRS), composed of Senators and Representatives, reviews proposed regulations to determine if "legislative intent" is met. ARRS options include:

- Approve
- Amend, provided the Agency and ARRS agree
- Defer a decision until a later meeting
- Find the proposed regulation deficient (fails to meet legislative intent)

(4) Governor Review of Deficient Regulation

If ARRS finds a regulation deficient, the regulation is referred to the Governor's office. The Governor may:

- Veto the proposed regulation
- Order it to be implemented
- Permit the regulation to be temporarily implemented until the next Session of the Kentucky General Assembly Adjourns *sine die* (end of Session)

(5) Legislative Interim Joint Committee Overview

The jurisdictional committee or Interim Legislative Joint Committee (ie, Health and Welfare Committee) normally assigned legislation related to the regulation has 30 days to make the final review. The Interim Committee is responsible for determining if a particular regulation meets "legislative intent."

The jurisdictional committee may:

- Find the regulation deficient and refer it to the full General Assembly
- Find a "deficient regulation" in compliance
- Approve the Regulation



2000

THERE'S A DOCTOR IN
THE HOUSE
... AND EXECUTIVE BRANCH



Lt Governor Steve Henry, MD



Representative
Bob M. DeWeese, MD



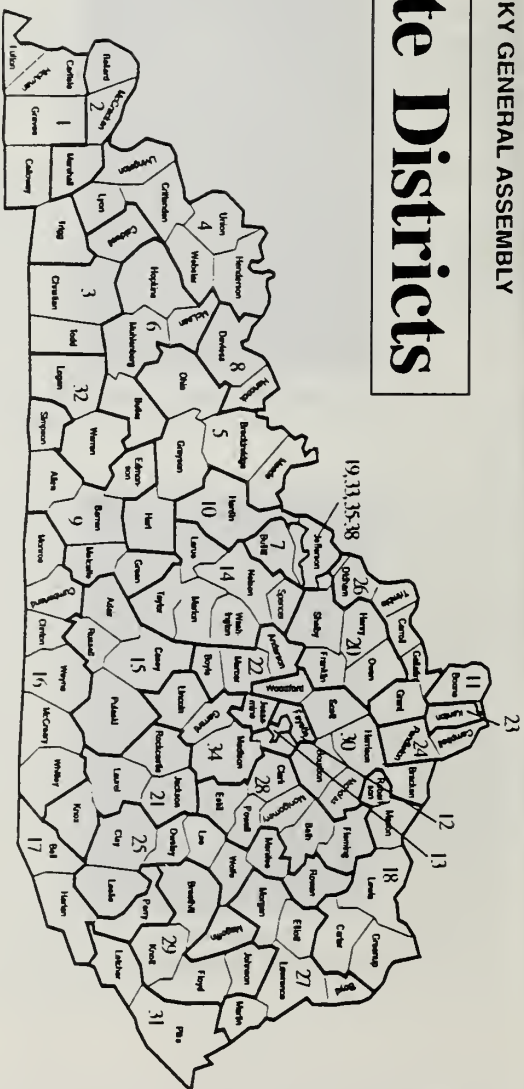
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KENTUCKY'S SENATE DISTRICTS

KENTUCKY GENERAL ASSEMBLY

Senate Districts



Legislative Research Commission

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President Pro Tem	Joey Pendleton (D)

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Democrats

Floor Leader	David K. Karem
Caucus Chairman	Gary Johnson
Whip	Walter Blevins, Jr

Republicans

Floor Leader	David L. Williams
Caucus Chairman	Charlie Borders
Whip	Elizabeth Tori





2000

SENATORS BY DISTRICT

SENATE

- 1 Robert L. Jackson
- 2 Robert J. Leeper
- 3 Joey Pendleton
- 4 Paul Herron, Jr
- 5 Virgil Moore
- 6 Richard "Dick" Adams
- 7 Lindy Casebier
- 8 David E. Boswell
- 9 Richard A. Sanders
- 10 Elizabeth Tori
- 11 Richard L. Roeding
- 12 Alice Forgy Kerr
- 13 Ernesto Scorsone
- 14 Dan Kelly
- 15 Vernie McGaha
- 16 David L. Williams
- 17 Glenn Freeman
- 18 Charlie Borders
- 19 Tim Shaughnessy
- 20 Marshall Long
- 21 Albert L. Robinson
- 22 Tom Buford
- 23 John D. "Jack" Westwood
- 24 Katie K. Stine
- 25 Robert Stivers
- 26 Ernie Harris
- 27 Walter Blevins, Jr
- 28 Dale Shrout
- 29 Benny Ray Bailey
- 30 Ed Miller
- 31 Gary C. Johnson
- 32 Brett Guthrie
- 33 Gerald A. Neal
- 34 Ed Worley
- 35 David K. Kareem
- 36 Julie C. Rose
- 37 Larry L. Saunders
- 38 Dan "Malano" Seum

COMMITTEE ROSTER KENTUCKY GENERAL ASSEMBLY

Committees of the Senate

Appropriations & Revenue

Bailey, Chair	McGaha
Sanders, Vice Chair	Miller
Casebier	Moore
Freeman	Neal
Guthrie	Saunders
Herron	Stivers
Kelly	Worley
Long	

Banking & Insurance

Buford, Chair	Robinson
Jackson, Vice Chair	Roeding
Harris	Sanders
Leeper	Seum
Long	Stivers
Pendleton	

Economic Development & Labor

Freeman, Chair	Johnson
McGaha, Vice Chair	Moore
Adams	Roeding
Blevins	Seum
Borders	Stine
Boswell	

Health & Welfare

Rose, Chair	Pendleton
Herron, Vice Chair	Roeding
Borders	Scorsone
Buford	Stine
Leeper	Westwood
Miller	

Judiciary

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Stine, Vice Chair	Shrout
Johnson	Tori
Karem	Westwood
Kerr	Williams
Neal	



2000

SENATE

Licensing & Occupations

Shrout, Chair	Leeper
Roeding, Vice Chair	Rose
Boswell	Seum
Buford	Shaughnessy
Johnson	Tori
Kerr	

State & Local Government

Robinson, Chair	Karem
Miller, Vice Chair	Kerr
Bailey	Rose
Blevins	Tori
Freeman	Williams
Harris	

Transportation

Scorsone, Chair	Pendleton
Moore, Vice Chair	Robinson
Blevins	Sanders
Borders	Shaughnessy
Jackson	Worley
Kelly	

Rules

Saunders, Chair	Pendleton
Karem, Vice Chair	Stivers
Blevins	Tori
Borders	Williams
Johnson	

NOTE: The above-listed committees are those to which health and medical issues are generally referred.

"Being in politics is like being a football coach. You have to be smart enough to understand the game and dumb enough to think it's important."

— EUGENE McCARTHY



2000

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KENTUCKY STATE SENATE

Richard "Dick" Adams D-6

PO Box 756
Madisonville, KY 42431
(502) 821-8544 (H)
(502) 825-1450 (O)
Butler, Hopkins, McLean, Muhlenburg
Profession: Attorney
Education: U of KY, BS, JD
Committee Assignments: Judiciary



Benny Ray Bailey D-29

PO Box 849
Hindman, KY 41822
(606) 785-5327 (H)
(606) 785-3164 (O)
Breathitt, Floyd, Johnson, Knott
Profession: Health Care Administrator
Education: Alice Lloyd College, AA;
Pikeville College, BA; Indiana State
U, MS; Ohio University, PhD
Committee Assignments:
Appropriations & Revenue, State
& Local Government



Walter Blevins, Jr D-27

777 Broadway
West Liberty, KY 41472
(606) 743-1200 (H)
(606) 743-4128 (O)
Boyd, Elliot, Lawrence, Martin,
Morgan
Profession: Dentist
Education: U of K, DMD
Committee Assignments:
Transportation, Economic
Development & Labor, Health
& Welfare, Rules



"Good legislation is in the eye of the beholder."

— CARL COOPER JR, MD
KMA PRESIDENT 1978-1979

Charlie Borders R-18

330 Seaton Drive
Russell, KY 41169
(606) 836-1721 (H)
(606) 324-5755 (O)
Carter, Greenup, Lewis, Mason,
Robertson
Profession: Realtor
Education: Ashland CC; Southeastern
Christian College; Morehead State
U, BS, MBA
Committee Assignments: Banking & Insurance,
Appropriations & Revenue



David E. Boswell D-8

2130 Woodland Drive
Owensboro, KY 42301
(502) 771-4921 (H)
(502) 684-2490 (O)
Davies, Hancock
Profession: Hotel Sales Executive
Education: Western KY U; Brescia
College
Committee Assignments:
Transportation, Licensing &
Occupations, Economic
Development & Labor



Tom Buford R-22

105 Crosswoods Place
Nicholasville, KY 40356
(606) 223-7171 (H)
Anderson, Boyle, Fayette, Jessamine,
Mercer
Profession: Building Contractor
Education: U of K, BS; American
Institute of Banking
Committee Assignments: Banking &
Insurance, Health & Welfare, Rules,
Licensing & Occupations



Lindy Casebier R-7

3304 Hardwood Forest Drive
Louisville, KY 40214
(502) 935-4085 (H)
Bullitt, Jefferson
Profession: Teacher
Education: U of L, MA
Committee Assignments:
Appropriations & Revenue, Banking
& Insurance



Glenn Freeman D-17

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 Cumberland, KY 40823
 (606) 589-5411 (H)
 (606) 589-4438 (O)
 Bell, Harlan, Perry
 Profession: Automobile Dealer
 Education: Cumberland College;
 Western KY U; U of K
 Committee Assignments:
 Appropriations & Revenue, State &
 Local Government, Economic
 Development & Labor



Brett Guthrie R-32

1005 Wrenwood Drive
 Bowling Green, KY 42103
 (502) 781-5597 (H)
 (502) 781-0048 (O)
 Logan, Warren
 Profession: Plant Manager
 Education: US Military Academy, BS;
 Yale U, MPPM
 Committee Assignments:
 Appropriations & Revenue



Ernie Harris R-26

PO Box 1073
 Crestwood, KY 40014
 (502) 241-8307 (H)
 Carroll, Gallatin, Grant, Jefferson,
 Oldham, Trimble
 Profession: Airline Pilot
 Education: U of K, BBA; Webster U,
 MM
 Committee Assignments: State & Local
 Government



Paul Herron, Jr D-4

2382 Wood Dr, Apt B
 Henderson, KY 42420
 (502) 827-5480 (H)
 (502) 826-6216 (O)
 Crittenden, Henderson, Livingston,
 Lyon, Union, Webster
 Profession: Auctioneer/Realtor
 Education: Indiana U
 Committee Assignments: Health &
 Welfare, State & Local Government



Robert L. Jackson D-1

PO Box 790

Murray, KY 42071

(502) 753-6463 (H)

(502) 753-1362 ext. 129 (O)

Calloway, Carlisle, Fulton, Graves,
Hickman, Trigg

Profession: Marketing Company
President

Education: Murray State U, BS

Committee Assignments: Banking &
Insurance, Economic Development & Labor



Gary C. Johnson D-31

111 Hickory Lane

Pikeville, KY 41502

(606) 437-4610 (H)

(606) 437-4002 (O)

Letcher, Pike

Profession: Attorney

Education: Berea College, BS; U of K,
JD

Committee Assignments:
Appropriations & Revenue, Judiciary,
State & Local Government



David K. Karem D-35

2439 Ransdell Avenue

Louisville, KY 40204

(502) 454-4174 (H)

(502) 574-3768 (O)

Jefferson

Profession: Attorney

Education: U of Cincinnati, BS; U of
L, JD

Committee Assignments: Judiciary,
Rules, State & Local Government



Dan Kelly R-14

324 West Main Street

Springfield, KY 40069

(606) 336-9048 (H)

(606) 336-7723 (O)

LaRue, Marion, Nelson, Spencer,
Taylor, Washington

Profession: Attorney

Education: Texas A & M, BS; U of L, JD

Committee Assignments: Rules,
Transportation, Licensing & Occupations



Alice Forgy Kerr R-12

3274 Gondola Drive
Lexington, KY 40513
(606) 223-3275 (H)
Fayette
Profession: Community Volunteer
Education: Western KY U, BS, MA
Committee Assignments: Judiciary,
Licensing & Occupations, State &
Local Government

**Robert J. Leeper R-2**

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Paducah, KY 42003
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Ballard, McCracken, Marshall
Profession: Chiropractor
Education: Paducah CC; Sherman
College of Chiropractic
Committee Assignments:
Transportation, Economic
Development & Labor

**Marshall Long D-20**

PO Box 505
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(502) 633-7462 (O)
Franklin, Henry, Jefferson, Owen,
Shelby
Profession: Businessman
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Committee Assignments:
Appropriations & Revenue,
Banking & Insurance

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Russell Springs, KY 42642
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Adair, Casey, Pulaski, Russell
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BS; Western KY U, MA
Committee Assignments: State & Local
Government



Ed Miller D-30

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Bourbon, Bracken, Harrison,
Nicholas, Scott, Woodford
Profession: College Professor
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Committee Assignments:

Appropriations & Revenue, Health
& Welfare



Virgil Moore R-5

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Leitchfield, KY 42754
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Breckinridge, Grayson, Hart, Meade,
Ohio
Profession: Farmer
Education: Eastern KY U, BS
Committee Assignments:

Transportation, Appropriations &
Revenue, Economic Development
& Labor



Gerald A. Neal D-33

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Jefferson
Profession: Attorney
Education: KY State U, BA; U of L, JD;
U of Michigan
Committee Assignments: Health &
Welfare, Judiciary



Joey Pendleton D-3

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Caldwell, Christian, Todd
Profession: Dairy Farmer
Education: Hopkinsville CC; Murray
State U
Committee Assignments:
Appropriations & Revenue, Health
& Welfare



Albert L. Robinson R-21

1249 South Main Street
London, KY 40741
(606) 843-6606 (H)
(606) 878-6877 (O)
Jackson, Knox, Laurel, Rockcastle
Profession: Real Estate Broker,
Auctioneer
Education: Cumberland College, BS
Committee Assignments: State & Local
Government, Banking & Insurance,
Transportation



Richard L. Roeding R-11

2534 Kearney Court
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(606) 331-1684 (H)
Boone, Kenton
Profession: Retired Pharmacist
Education: Xavier U; U of Cincinnati
Committee Assignments: Banking &
Insurance, Health & Welfare,
Licensing & Occupations, Rules



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4600 Doe Spring Court
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(502) 228-7673 (H)
Jefferson
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Committee Assignments: Health &
Welfare, Judiciary, State & Local
Government



Richard A. Sanders R-9

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Franklin, KY 42134
(502) 586-5473 (H)
Allen, Barren, Edmonson, Green,
Metcalf, Simpson
Profession: Farmer, Restaurant Owner
Education: Western KY U
Committee Assignments:
Appropriations & Revenue,
Economic Development & Labor



Larry L. Saunders D-37

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Jefferson

Profession: Attorney

Education: U of L, BA, JD

Committee Assignments:

Appropriations & Revenue,
Judiciary, Rules



Ernesto Scorsone D-13

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Lexington, KY 40507
(606) 254-3681 (H)
(606) 254-5766 (O)

Fayette

Profession: Attorney

Education: U of K, BA, JD

Committee Assignments: Banking &
Insurance, Judiciary



Dan "Malano" Seum R-38

4709 South Second Street
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(502) 366-4748 (H)
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Jefferson

Profession: Restaurant Owner

Committee Assignments: Banking &
Insurance, Licensing &
Occupations, Health & Welfare



Tim Shaughnessy D-19

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Louisville, KY 40202
(502) 267-5063 (H)
(502) 584-1920 (O)

Jefferson

Profession: Hospital VP

Education: Jefferson CC; U of L, BS;
Bellarmine College, MBA

Committee Assignments: Banking &
Insurance, Economic Development & Labor



Dale Shrout D-28

112 Apperson Heights
Mt. Sterling, KY 40353
(606) 498-3045 (H)
Bath, Clark, Estill, Fleming,
Montgomery, Powell
Profession: Businessman, Investor
Committee Assignments: Judiciary,
Licensing & Occupations



Katie K. Stine R-24

15 Cliffview Avenue
Ft. Thomas, KY 41075
(606) 781-5311 (H)
Campbell, Pendleton
Profession: Attorney
Education: U of Cincinnati, BS; Chase
College of Law, JD
Committee Assignments: Health &
Welfare, Judiciary



Robert Stivers R-25

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(606) 598-2322 (O)
Clay, Lee, Leslie, Magoffin, Menifee,
Owsley, Rowan, Wolfe
Profession: Attorney
Education: U of K, BS; U of L, JD
Committee Assignments: State & Local
Government, Economic Development
& Labor



Elizabeth Tori R-10

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Radcliff, KY 40160
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(502) 351-1827 (O)
Hardin, Jefferson
Profession: Business Owner
Education: U of K; Western KY U
Committee Assignments: Judiciary,
State & Local Government, Banking
& Insurance, Rules



John D. "Jack" Westwood R-23

36 Forest Avenue
Erlanger, KY 41018
(606) 727-1187 (H)
Kenton

Profession: Retired Teacher, Salesman

Education: U of K, BA, Northern KY
U, M.Ed

Committee Assignments: Health &
Welfare, Judiciary



David L. Williams R-16

PO Box 666
Burkesville, KY 42717
(502) 433-7777 (H)
(502) 864-5636 (O)

Clinton, Cumberland, McCreary,
Monroe, Whitley

Profession: Attorney

Education: U of K, BS; U of L, JD

Committee Assignments: Judiciary,
Appropriations & Revenue, Economic
Development & Labor



Ed Worley D-34

PO Box 659
Richmond, KY 40475
(606) 623-6504 (H)
(606) 623-1000 (O)

Fayette, Garrard, Lincoln, Madison

Profession: City Manager

Education: Eastern KY U, BA

Committee Assignments:
Appropriations & Revenue,
Transportation



Today's Physician

- 62% of physicians are self-employed, and 36% are employees
- 36% of physicians are in solo practice, and 19% are in 2-3 physician groups
- 22% of physicians are in 4-8 physician groups, and nearly 1/4 are in groups with >8 physicians



2000

HOUSE LEADERSHIP

ELECTIVE OFFICERS

Speaker	Jody Richards (D)
Speaker Pro Tem	Larry Clark (D)

PARTY LEADERS

Democrats

Floor Leader	Gregory D. Stumbo
Caucus Chairman	Jim Callahan
Whip	Joe Barrows

Republicans

Floor Leader	Danny R. Ford
Caucus Chairman	Jeff Hoover
Whip	Woody Allen

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2000

REPRESENTATIVES BY DISTRICT

HOUSE

- | | |
|-----------------------------|--------------------------------|
| 1 Charles R. Geveden | 52 Ken Upchurch |
| 2 Fred Nesler | 53 Billy D. Polston |
| 3 Frank Rasche | 54 John W. Bowling |
| 4 Mike Cherry | 55 Jack L. Coleman |
| 5 Robert Buckingham | 56 Joseph Howard "Joe" Barrows |
| 6 J.R. Gray | 57 H.G. "Gippy" Graham |
| 7 John A. Arnold, Jr | 58 Gary Tapp |
| 8 John W. Adams | 59 Tim Feeley |
| 9 James E. Bruce | 60 Paul H. Marcotte |
| 10 Joseph Eddie Ballard | 61 Royce W. Adams |
| 11 Gross C. Lindsay | 62 Charles R. Hoffman |
| 12 Jim Gooch, Jr | 63 Jon E. Draud |
| 13 Brian J. Crall | 64 Thomas Robert Kerr |
| 14 Mark A. Treesh | 65 Arnold Simpson |
| 15 Brent Yonts | 66 Charlie Walton |
| 16 Sheldon E. Baugh | 67 James P. Callahan |
| 17 Willard C. "Woody" Allen | 68 Joe Fischer |
| 18 Dwight D. Butler | 69 Jon David Reinhardt |
| 19 Dottie J. Sims | 70 Pete Worthington |
| 20 Jody Richards | 71 John Will Stacy |
| 21 Roger Thomas | 72 Carolyn Belcher |
| 22 Rob Wilkey | 73 R.J. Palmer, II |
| 23 Stephen R. Nunn | 74 Adrian K. Arnold |
| 24 William U. Scott | 75 Kathy W. Stein |
| 25 Jimmie Lee | 76 Ruth Ann Palumbo |
| 26 John Michael Weaver | 77 Jesse Crenshaw |
| 27 James H. Thompson | 78 Thomas M. McKee |
| 28 Charles Miller | 79 Susan Westrom |
| 29 Kevin D. Bratcher | 80 Danny R. Ford |
| 30 Thomas J. Burch | 81 Harry Moberly |
| 31 Steven R. Riggs | 82 Charles L. Siler |
| 32 Susan D. Johns | 83 Jeffrey H. Hoover |
| 33 Bob Heleringer | 84 Scott Alexander |
| 34 Mary Lou Marzian | 85 Thomas J. Turner |
| 35 Jim Wayne | 86 Jim Stewart |
| 36 Lonnie Napier | 87 J.C. "Bo" Ausmus, III |
| 37 Perry B. Clark | 88 Johnnie Turner |
| 38 Denver Butler | 89 Marie L. Rader |
| 39 Robert R. Damron | 90 Barbara W. Colter |
| 40 Dennis Horlander | 91 Howard Cornett |
| 41 Tom Riner | 92 Phillip Childers |
| 42 Eleanor Jordan | 93 Chris Ratliff |
| 43 E. Porter Hatcher, Jr | 94 Ira E. Branham |
| 44 Joni L. Jenkins | 95 Gregory D. Stumbo |
| 45 Stanton L. Cave | 96 Robin L. Webb |
| 46 Larry D. Clark | 97 Hubert Collins |
| 47 Ronald E. Crimm | 98 Hobart W. "Hoby" Anderson |
| 48 Bob M. DeWeese | 99 Rocky Adkins |
| 49 Larry L. Belcher | 100 John F. Vincent |
| 50 Joseph A. "Jodie" Haydon | |
| 51 Ricky L. Cox | |

COMMITTEE ROSTER KENTUCKY GENERAL ASSEMBLY

Committees of the House

Appropriations & Revenue

Harry Moberly, Chair	Jesse Crenshaw
Scott Alexander, Vice Chair	Danny Ford
Robert Damron, Vice Chair	Porter Hatcher, Jr
Bob DeWeese, Vice Chair	Jimmie Lee
Susan Johns, Vice Chair	Mary Lou Marzian
Rob Wilkey, Vice Chair	Lonnie Napier
Royce Adams	Fred Nesler
Rocky Adkins	Stephen Nunn
Joe Barrows	Charles Siler
Dwight Butler	John Will Stacy
Jim Callahan	Mark Treesh
Larry Clark	John Vincent
Jack Coleman	Jim Wayne
Barbara Colter	Pete Worthington

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Sheldon Baugh, Vice Chair	Susan Johns
Ira Branham, Vice Chair	Billy Polston
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John Adams	Steve Riggs
Stanton Cave	Arnold Simpson
Brian Crall	Dottie Sims
Ron Crimm	Roger Thomas
Robert Damron	Ken Upchurch
Charles Geveden	Rob Wilkey

Elections, Constitutional Amendments & Intergovernmental Affairs

Adrian Arnold, Chair	Woody Allen
Hoby Anderson, Vice Chair	Joe Barrows
Perry Clark, Vice Chair	Stanton Cave
Mary Lou Marzian, Vice Chair	Gross Lindsay



2000

Health & Welfare

Tom Burch, Chair
Bob DeWeese, Vice Chair
Susan Johns, Vice Chair
Stephen Nunn, Vice Chair
Kathy Stein, Vice Chair
John Arnold, Jr
Bo Ausmus
John Bowling
Brian Crall

Robert Damron
James Gooch
Bob Heleringer
Eleanor Jordan
Mary Lou Marzian
Ruth Ann Palumbo
Jon David Reinhardt
Arnold Simpson
Susan Westrom

Judiciary

Gross Lindsay, Chair
Stanton Cave, Vice Chair
Susan Westrom, Vice Chair
Rob Wilkey, Vice Chair
Brent Yonts, Vice Chair
Ira Branham
Kevin Bratcher
Perry Clark
Jesse Crenshaw

Joseph Fischer
Charles Geveden
Bob Heleringer
Jeffrey Hoover
Joni Jenkins
Thomas Kerr
Frank Rasche
Kathy Stein
John Vincent

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Hoby Anderson, Vice Chair
Charlie Hoffman, Vice Chair
Joni Jenkins, Vice Chair
Denver Butler
Ricky Cox
Dennis Horlander

Eleanor Jordan
Stephen Nunn
Jim Stewart
Johnnie Turner
Tommy Turner
Brent Yonts

Licensing & Occupations

Denver Butler, Chair
Porter Hatcher, Jr, Vice Chair
Charles Miller, Vice Chair
Jon David Reinhardt,
Vice Chair
Tom Burch
Larry Clark

Ron Crimm
Jon Draud
Dennis Horlander
Eleanor Jordan
Paul Marcotte
Ruth Ann Palumbo
Jim Stewart

Rules

Jody Richards, Chair
 Rocky Adkins
 Woody Allen
 Adian Arnold
 Joe Barrows
 Sheldon Baugh
 Jim Callahan
 Stanton Cave
 Larry Clark
 Jack Coleman
 Bob DeWeese

Danny Ford
 Charles Geveden
 Porter Hatcher, Jr
 Thomas Kerr
 Jimmie Lee
 Fred Nesler
 Steve Riggs
 John Will Stacy
 Greg Stumbo
 Rob Wilkey

State Government

Charles Geveden, Chair
 Eddie Ballard, Vice Chair
 James Bruce, Vice Chair
 Buddy Buckingham, Vice Chair
 Mike Cherry, Vice Chair
 Paul Marcotte, Vice Chair
 Lonnie Napier, Vice Chair
 John Adams
 Joe Barrows
 Carolyn Belcher
 Dwight Butler

Jim Callahan
 Larry Clark
 Brian Crall
 Tim Feeley
 Jimmie Lee
 Chris Ratliff
 Jon David Reinhardt
 John Will Stacy
 Jim Wayne
 Robin Webb
 Pete Worthington

Transportation

Hubert Collins, Chair
 Larry Belcher, Vice Chair
 Chris Ratliff, Vice Chair
 William Scott, Vice Chair
 John Will Stacy, Vice Chair
 Rocky Adkins
 John Arnold
 Eddie Ballard
 John Bowling
 Ira Branham
 Denver Butler

Barbara Colter
 Jodie Haydon
 Jimmie Lee
 Paul Marcotte
 Charles Miller
 Lonnie Napier
 Marie Rader
 Tommy Turner
 John Vincent
 Mike Weaver
 Pete Worthington

NOTE: The above-listed committees are those to which health and medical issues are generally referred.

"The credit in life does not go to the critic who stands on the sideline and points out where the strong stumble, but rather, the real credit in life goes to the man who is actually in the arena, whose face may get marred by sweat and dust, who knows great enthusiasm and great devotion and learns to spend himself in a worthy cause, who, at best if he wins, knows the thrill of high achievement and if he fails, at least fails while daring greatly, so that in life his place will never be with those very cold and timid souls who know neither victory nor defeat."

— THEODORE ROOSEVELT

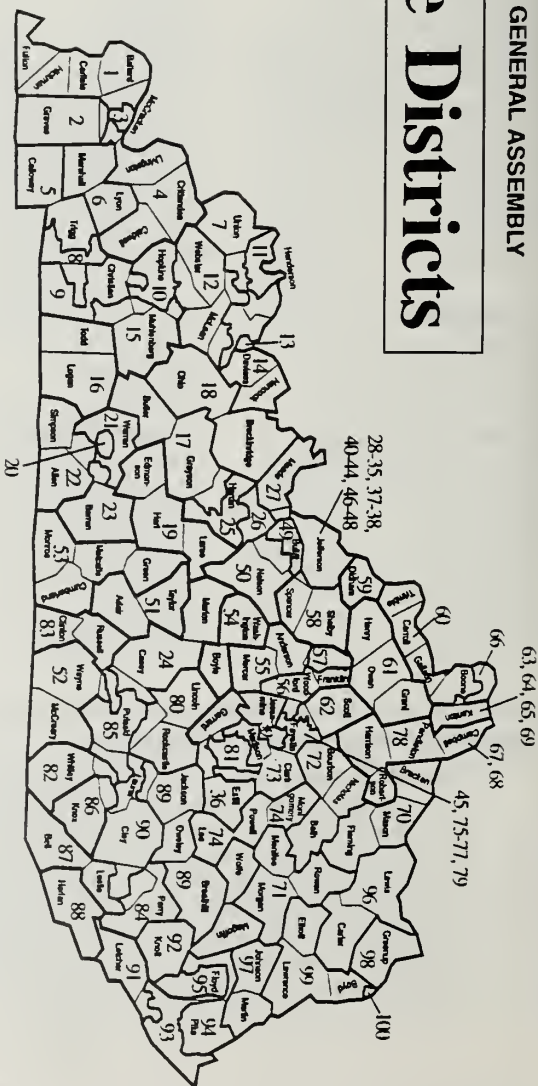


2000

KENTUCKY'S HOUSE DISTRICTS

KENTUCKY GENERAL ASSEMBLY

House Districts



Legislative Research Commission

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HOUSE



2000

KENTUCKY HOUSE OF REPRESENTATIVES

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John W. Adams D-8

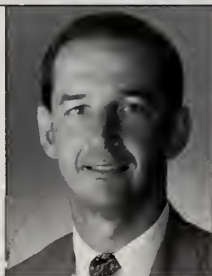
6255 Huffman Mill Road
Hopkinsville, KY 42240
(502) 886-7087 (H)
Christian, Trigg
Profession: Farmer & Real Property
Appraiser
Education: U of K, BS, MS
Committee Assignments: Banking &
Insurance, State Government

**Royce W. Adams D-61**

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(606) 428-1039 (H)
(606) 824-3387 (O)
Grant, Henry, Owen
Profession: Horse Farmer
Committee Assignments:
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**Rocky Adkins D-99**

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(606) 928-3433 (O)
Boyd, Elliott, Lawrence
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Committee Assignments:
Appropriations & Revenue, Rules,
Transportation

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Leslie, Perry
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Committee Assignments:
Appropriations & Revenue



Willard C. "Woody" Allen R-17

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(502) 526-5149 (H)
Butler, Grayson, Hardin
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Committee Assignments: Rules,
Elections & Constitutional
Amendments



Hobart W. "Hoby" Anderson R-98

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Greenup
Profession: CPA, Small Business
Owner
Education: U of K, BS; Morehead
State U, MBA
Committee Assignments: Elections &
Constitutional Amendments,
Labor & Industry



Adrian K. Arnold D-74

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Lee, Montgomery, Powell
Profession: Farmer
Education: Morehead State U
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Constitutional Amendments, Rules



John A. Arnold, Jr D-7

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Daviess, Henderson, Union
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Education: Lincoln Chiropractic
College
Committee Assignments: Health &
Welfare, Transportation



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Welfare

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Hopkins
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Committee Assignments: State
Government, Transportation

**Joseph Howard "Joe" Barrows
D-56**

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Profession: Attorney
Education: DePauw U, BA; U of K, JD
Committee Assignments:
Appropriations & Revenue,
Elections & Constitutional
Amendments, State Government,
Rules

**Sheldon E. Baugh R-16**

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Logan, Todd
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Education: Western KY U
Committee Assignments: Banking &
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Carolyn Belcher D-72

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Bath, Bourbon, Fayette, Nicholas
Profession: CPA
Education: U of K, BS
Committee Assignments: State
Government



Larry L. Belcher R-49

4804 Hickory Hollow Lane
Shepherdsville, KY 40165
(502) 955-7584 (H)
(502) 543-2271 (O)
Bullitt
Profession: Communications
Specialist
Education: Sullivan Junior College
Committee Assignments:
Transportation



John W. Bowling D-54

406 Maple Avenue
Danville, KY 40422
(606) 236-8954 (H)
Boyle, Washington
Profession: Businessman
Committee Assignments: Health &
Welfare, Transportation



Ira E. Branham D-94

Box 1499
Pikeville, KY 41502
(606) 432-3215 (H)
(606) 432-2704 (O)
Floyd, Pike
Profession: Attorney
Education: U of L, JD
Committee Assignments: Banking &
Insurance, Judiciary, Transportation



Kevin D. Bratcher R-29

5205 Constance Drive
Louisville, KY 40272
(502) 933-7938 (H)
(502) 327-7424 (O)
Jefferson
Profession: Technical School Instructor
Education: Embry-Riddle Aeronautical
U, BS
Committee Assignments: Judiciary


James E. Bruce D-9

6750 Ft Campbell Boulevard
Hopkinsville, KY 42240
(502) 886-2422 (H)
Christian, Hopkins
Profession: Farmer
Education: U of Tennessee, BS
Committee Assignments: Banking &
Insurance, State Government


Robert Buckingham D-5

1717 Magnolia Drive
Murray, KY 42071
(502) 753-5841 (H)
Calloway, Trigg
Profession: Teacher
Education: Murray State U, BS, MA
Committee Assignments: State
Government


Thomas J. Burch D-30

4012 Lambert Avenue
Louisville, KY 40218
(502) 454-4002 (H)
Jefferson
Profession: Retired Production
Manager
Education: Bellarmine College, BA
Committee Assignments: Health &
Welfare, Licensing & Occupations



Denver Butler D-38

6712 Morocco Drive

Louisville, KY 40214

(502) 366-7195 (H)

Jefferson

Profession: Sales, Construction
Equipment

Education: Jefferson Community
College

Committee Assignments: Labor &
Industry, Licensing & Occupations,
Transportation



Dwight D. Butler R-18

PO Box 194

Harned, KY 40144

(502) 756-0100 (H)

(502) 756-5931 (O)

Breckinridge, Ohio

Profession: Auctioneer, Real Estate
Broker

Education: Eastern KY U, BA

Committee Assignments:
Appropriations & Revenue, State
Government



James P. Callahan D-67

10 Colonel Pointe Drive

Wilder, KY 41076

(606) 781-1232 (H)

(606) 441-7400 (O)

Campbell

Profession: Human Resources
Manager

Education: Thomas More College

Committee Assignments:
Appropriations & Revenue, Rules,
State Government



Stanton L. Cave R-45

4012 Clearwater Lane

Lexington, KY 40515-6002

(606) 273-7106 (H)

(606) 255-9500 (O)

Fayette

Profession: Attorney

Education: U of K, BS, JD

Committee Assignments: Banking &
Insurance, Elections & Constitu-
tional Amendments, Judiciary, Rules



Mike Cherry R-4

803 South Jefferson Street
 Princeton, KY 42445
 (502) 365-7801 (H)
 Caldwell, Crittenden, Livingston,
 McCracken
 Profession: Business Owner
 Education: Murray State U, BS;
 Southern Illinois U, MS
 Committee Assignments: State
 Government

**Phillip Childers D-92**

PO Box 20
 Garner, KY 41817
 (606) 785-5156 (H)
 (606) 785-4938 (O)
 Knott, Magoffin, Wolfe
 Profession: Business Owner
 Committee Assignments:

**Larry D. Clark D-46**

5913 Whispering Hills Blvd
 Louisville, KY 40219
 (502) 968-3546 (H)
 (502) 583-0569 (O)
 Jefferson
 Profession: Electrician
 Committee Assignments:
 Appropriations & Revenue,
 Licensing & Occupations, State
 Government, Rules.

**Perry B. Clark D-37**

5716 New Cut Road
 Louisville, KY 40214
 (502) 366-1247 (H)
 (502) 933-5254 Ext. 345 (O)
 Jefferson
 Profession: Quality Training
 Education: U of L
 Committee Assignments: Elections
 & Constitutional Amendments,
 Judiciary



Jack L. Coleman D-55

PO Box 600
Burgin, KY 40310
(606) 748-5947 (H)
(606) 734-4334 (O)
Anderson, Franklin, Mercer
Profession: Lumber Company Owner
Education: Eastern KY U
Committee Assignments:
Appropriations & Revenue, Rules



Hubert Collins D-97

72 Collins Drive
Wittensville, KY 41274
(606) 297-3152 (H)
(606) 297-3361 (O)
Johnson, Martin
Profession: Teacher, Car Dealer,
Realtor
Education: Morehead State U, BA, MA
Committee Assignments:
Transportation



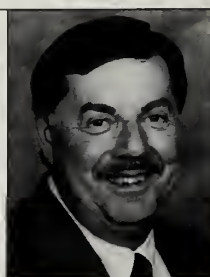
Barbara W. Colter R-90

200 Langdon Avenue
Manchester, KY 40962
(606) 598-2833 (H)
(606) 598-5111 (O)
Clay, Laurel, Leslie
Profession: Educational Supervisor,
Store Owner
Education: Cumberland College, BS;
Union College, MA, Eastern KY U
Committee Assignments:
Appropriations & Revenue,
Transportation



Howard Cornett R-91

20 El Paso
Whitesburg, KY 41858
(606) 633-3124 (H)
(606) 832-4827 (O)
Letcher, Pike
Profession: Radio Station Owner
Education: Eastern KY U
Committee Assignments:



Ricky L. Cox R-51

603 Maple Street
Campbellsville, KY 42718
(502) 465-7580 (H)
(502) 465-8005 (O)
Adair, Taylor
Profession: Dentist
Education: Campbellsville College,
BS; U of K, DMD
Committee Assignments: Labor &
Industry


Brian J. Crall R-13

3336 Bryant Court
Owensboro, KY 42303
(502) 683-8011 (H)
(502) 926-9622 (O)
Daviess
Profession: YMCA Executive
Education: Murray State U, BS
Committee Assignments: Banking &
Insurance,
Health & Welfare, State Government


Jesse Crenshaw D-77

117 Constitution Street
Lexington, KY 40507
(606) 252-6967 (H)
(606) 259-1402 (O)
Fayette
Profession: Attorney
Education: KY State, BA; U of K, JD
Committee Assignments:
Appropriations & Revenue,
Judiciary


Ronald E. Crimm R-47

PO Box 43244
Louisville, KY 40253
(502) 245-8905 (H)
(502) 245-2118 (O)
Jefferson
Profession: Insurance Agency Owner
Education: Shippensburg U, BS
Committee Assignments: Banking &
Insurance, Licensing & Occupations



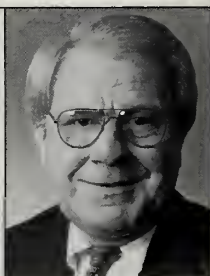
Robert R. Damron D-39

231 Fairway West
Nicholasville, KY 40536
(606) 887-1744 (H)
(606) 263-8009 (O)
Fayette, Jessamine
Profession: Correspondent Banker
Education: U of K, BS, MBA
Committee Assignments:
Appropriations & Revenue,
Banking & Insurance, Health
& Welfare



Bob M. DeWeese R-48

6206 Glen Hill Road
Louisville, KY 40222
(502) 426-5565 (H)
Jefferson
Profession: Physician
Education: U of K, BS; U of L, MD
Committee Assignments:
Appropriations & Revenue, Health
& Welfare, Rules



Jon E. Draud R-63

109 Vernon Drive
Crestview Hills, KY 41017
(606) 341-3831 (H)
(606) 261-8210 (O)
Kenton
Profession: College Professor
Education: Eastern KY U, BA; Xavier
U, MA; U of Cincinnati, EdD
Committee Assignments: Licensing &
Occupations



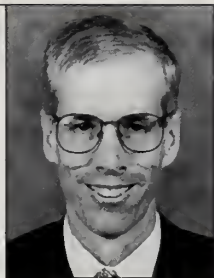
Tim Feeley R-59

PO Box 64
Crestwood, KY 40014
(502) 241-8473 (H)
(502) 241-7472 (O)
Jefferson, Oldham
Profession: Attorney
Education: U of Pennsylvania, BS;
West Virginia U, JD
Committee Assignments: State
Government



Joe Fischer R-68

11 Robannette Court
 Ft Thomas, KY 41075
 (606) 781-6965 (H)
 (513) 794-6442 (O)
 Campbell
 Profession: Attorney
 Education: Holy Cross College, BA; U
 of Cincinnati, JD
 Committee Assignments: Judiciary

**Danny R. Ford R-80**

PO Box 1245
 Mount Vernon, KY 40456
 (606) 256-4446 (H)
 (606) 256-5229 (O)
 Lincoln, Pulaski, Rockcastle
 Profession: Auctioneer & Realtor
 Education: Eastern KY U, BS
 Committee Assignments:
 Appropriations & Revenue, Rules

**Charles R. Geveden D-1**

PO Box 518
 Wickliffe, KY 42087
 (502) 335-3683 (H)
 (502) 335-3186 (O)
 Ballard, Carlisle, Fulton, Hickman,
 McCracken
 Profession: Attorney
 Education: Vanderbilt, BA; U of L, JD
 Committee Assignments: Banking &
 Insurance, Judiciary, Rules, State
 Government

**Jim Gooch, Jr D-12**

PO Box 280
 Providence, KY 42450
 (502) 667-7327 (H)
 (502) 667-7051 (O)
 Caldwell, Hopkins, McLean, Webster
 Profession: Insurance Agent
 Committee Assignments: Banking &
 Insurance, Health & Welfare



H.G. "Gippy" Graham D-57

1310 Louisville Road, No. 68

Frankfort, KY 40601

(502) 223-2601 (H)

(502) 564-8100 (O)

Franklin

Profession: Retired Educator

Education: Cumberland College, AA;

Georgetown College, BA; U of K,
MA

Committee Assignments:



J.R. Gray D-6

3188 Mayfield Highway

Benton, KY 42025

(502) 527-8376 (H)

Lyon, McCracken, Marshall

Profession: Consultant

Education: American School, Chicago

Committee Assignments: Labor &
Industry



E. Porter Hatcher, Jr D-43

901 Southwestern Parkway

Louisville, KY 40211

(502) 778-9051 (H)

(502) 774-2331 (O)

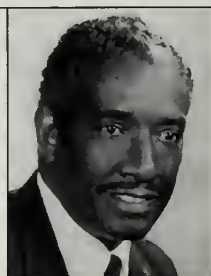
Jefferson

Profession: Insurance Agent & Realtor

Education: U of L

Committee Assignments:

Appropriations & Revenue,
Licensing & Occupations, Rules



Joseph A. "Jodie" Haydon D-50

106 Hillcrest

Bardstown, KY 40004

(502) 348-2815 (H)

(502) 348-3926 (O)

Bullitt, Nelson

Profession: Contractor

Education: Bellarmine College, BA

Committee Assignments:
Transportation



Bob Heleringer R-33

14209 Glendower Drive
Louisville, KY 40245
(502) 245-7173 (H)
(502) 584-6787 (O)
Jefferson

Profession: Attorney

Education: Xavier U, BA; U of L, JD

Committee Assignments:

Appropriations & Revenue, Health
& Welfare, Judiciary

**Charles R. Hoffman D-62**

406 Bourbon Street
Georgetown, KY 40324
(502) 863-9796 (H)
(502) 863-4807 (O)
Fayette, Scott

Profession: Meat Cutter, Real Estate
Broker, Auctioneer

Committee Assignments: Labor &
Industry

**Jeffrey H. Hoover R-83**

372 Lakeview Drive
Jamestown, KY 42629
(502) 343-2264 (H)
(502) 343-5588 (O)

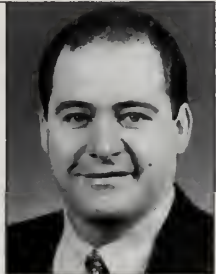
Clinton, Pulaski, Russell

Profession: Attorney

Education: Centre College, BA;

Cumberland College of Law, JD

Committee Assignments: Judiciary

**Dennis Horlander D-40**

1806 Farnsley Road, Suite 106
Louisville, KY 40216
(502) 447-6122 (H)
(502) 447-2498 (O)

Jefferson

Profession: Manufacturers
Representative

Education: U of L, BS

Committee Assignments: Labor &
Industry, Licensing & Occupations



Joni L. Jenkins D-44

2010 O'Brien Court
Shively, KY 40216
(502) 447-4324 (H)
Jefferson
Profession: Training Specialist
Education: U of K, BA
Committee Assignments: Judiciary,
Labor & Industry



Susan D. Johns D-32

3120 Runnymede Road
Louisville, KY 40222
(502) 426-6990 (H)
(502) 425-5050 (O)
Jefferson
Profession: Bank Executive
Education: Georgetown College, BA,
MA
Committee Assignments:
Appropriations & Revenue, Banking
& Insurance, Health & Welfare



Eleanor Jordan D-42

2704 Grand Avenue, Unit 2
Louisville, KY 40211
(502) 776-2958 (H)
(502) 775-8331 (O)
Jefferson
Profession: Child Care Director
Education: Western KY U; U of L
Committee Assignments: Health &
Welfare, Labor & Industry,
Licensing & Occupations



Thomas Robert Kerr D-64

5415 Old Taylor Mill Road
Taylor Mill, KY 41015
(606) 356-1344 (H)
(606) 431-2222 (O)
Kenton
Profession: Attorney
Education: U of K, BA; Chase College
of Law, JD
Committee Assignments: Judiciary,
Rules



Jimmie Lee D-25

901 Dogwood Drive
 Elizabethtown, KY 42701
 (502) 737-8889 (H)
 (502) 765-6222 (O)

Hardin

Profession: Retired Auto Dealer

Committee Assignments:

Appropriations & Revenue,
 Rules, State Government,
 Transportation

**Gross C. Lindsay D-11**

PO Box 19
 Henderson, KY 42420
 (502) 827-9824 (H)
 (502) 827-9825 (O)

Henderson

Profession: Attorney

Education: U of K, BA, JD

Committee Assignments: Elections &
 Constitutional Amendments,
 Judiciary

**Paul H. Marcotte R-60**

10674 Palestine Drive
 Union, KY 41091
 (606) 384-1097 (H)
 (606) 781-3800 (O)

Boone, Carroll, Gallatin, Trimble

Profession: Business Executive

Education: St. John's U, BA

Committee Assignments: Licensing &
 Occupations, State Government,
 Transportation

**Mary Lou Marzian D-34**

2007 Tyler Lane
 Louisville, KY 40205
 (502) 451-5032 (H)
 (502) 852-0781 (O)

Jefferson

Profession: Registered Nurse

Education: U of L, BSN

Committee Assignments:

Appropriations & Revenue,
 Elections & Constitutional Amendments, Health & Welfare



Thomas M. McKee D-78

Route 8, Box 56
Cynthiana, KY 41031
(606) 234-5879 (H)
Campbell, Harrison, Pendleton,
Robertson
Profession: Farmer
Education: Centre College, BA
Committee Assignments:



Charles Miller D-28

3608 Gatewood Circle
Louisville, KY 40272
(502) 937-7788 (H)
(502) 485-8311 (O)
Jefferson
Profession: High School Principal
Education: Western KY U, BS, MA,
Rank 1
Committee Assignments: Licensing &
Occupations, Transportation



Harry Moberly D-81

PO Box 721
Richmond, KY 40475
(606) 624-2781 (H)
(606) 622-1501 (O)
Madison
Profession: Attorney
Education: Eastern KY U, BA; U of L,
JD
Committee Assignments:
Appropriations & Revenue



Lonnie Napier R-36

302 Danville Street
Lancaster, KY 40444
(606) 792-4860 (H)
(606) 792-2325 (O)
Estill, Garrard, Madison
Profession: Auctioneer, Realtor, Retail
Stores
Committee Assignments:
Appropriations & Revenue, State
Government, Transportation



Fred Nesler D-2

PO Box 323
 Mayfield, KY 42066
 (502) 247-8557 (H)
 (502) 247-1258 (O)
 Graves, McCracken
 Profession: Farmer, Realtor
 Committee Assignments:
 Appropriations & Revenue, Rules

**Stephen R. Nunn R-23**

121 East Main Street
 Glasgow, KY 42141
 (502) 651-5552 (H)
 (502) 678-5452 (O)
 Barren, Warren
 Profession: Business Development
 Director
 Education: U of K; Transylvania U,
 BA; U of L School of Law
 Committee Assignments:
 Appropriations & Revenue, Health
 & Welfare, Labor & Industry

**R.J. Palmer, II D-73**

126 Shanahan Lane
 Winchester, KY 40391
 (606) 737-2945 (H)
 (606) 299-2579 (O)
 Clark, Madison
 Profession: Sales Representative
 Education: Transylvania U, BS; Eastern
 KY U, MBA
 Committee Assignments: Banking &
 Insurance

**Ruth Ann Palumbo D-76**

10 Deepwood Drive
 Lexington, KY 40505
 (606) 299-2597 (H)
 Fayette
 Profession: Legislator/Community
 Volunteer
 Education: U of K, BA
 Committee Assignments: Health &
 Welfare, Licensing & Occupations



Billy D. Polston R-53

PO Box 248
Tompkinsville, KY 42167-0248
(502) 487-5940 (H)
(502) 487-8911 (O)
Cumberland, Green, Metcalfe,
Monroe
Profession: Insurance Agent
Education: Lindsey Wilson College,
AA; KY School of Mortuary Science
Committee Assignments: Banking &
Insurance



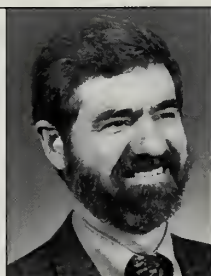
Marie L. Rader R-89

PO Box 323
McKee, KY 40447
(606) 287-7303 (H)
(606) 287-3300 (O)
Breathitt, Jackson, Laurel, Owsley
Profession: Self-employed
Education: Berea College
Committee Assignments:
Transportation



Frank Rasche D-3

2929 Jefferson Street
Paducah, KY 42001
(502) 443-5521 (H)
(502) 443-5167 (O)
McCracken
Profession: Store Owner
Education: Vanderbilt U, BA; Murray
State U, MA
Committee Assignments: Banking &
Insurance, Judiciary



Chris Ratliff R-93

PO Drawer 1379
Pikeville, KY 41502
(606) 432-0560 (O)
(606) 432-5310 (H)
Pike
Profession: Attorney
Education: Princeton U, BA; U of
Florida, JD
Committee Assignments: State
Government, Transportation



Jon David Reinhardt R-69

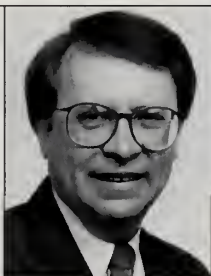
637 W. Poplar Thicket Road
 Alexandria, KY 41001
 (513) 397-6303 (O)
 (606) 635-3455 (H)
 Boone, Campbell, Kenton
 Profession: Landscape Business
 Owner

Education: U of K; U of Cincinnati
 Committee Assignments: Health &
 Welfare, Licensing & Occupations,
 State Government

**Jody Richards D-20**

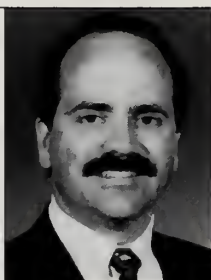
817 Culpeper Street
 Bowling Green, KY 42103
 (502) 781-9946 (O)
 (502) 842-6731 (H)
 Warren

Profession: Book Store Owner
 Education: KY Wesleyan College, AB;
 U of Missouri, MA; Indiana U
 Committee Assignments: Rules

**Steven R. Riggs D-31**

8108 Thornwood Dr
 Louisville, KY 40220
 (502) 244-1343 (O)
 (502) 499-6050 (H)
 Jefferson

Profession: Insurance Agent
 Education: U of K, BBA
 Committee Assignments: Banking &
 Insurance, Rules

**Tom Riner D-41**

1143 East Broadway
 Louisville, KY 40204
 (502) 583-3639 (O)
 (502) 584-3639 (H)
 Jefferson

Profession: Minister
 Education: Centre College;
 Southern Baptist Theological
 Seminary; Heritage Baptist U
 Committee Assignments:



William U. Scott D-24

260 Frogg Lane
Raywick, KY 40060
(502) 692-9229 (H)
Casey, Marion, Pulaski
Profession: Logging Contractor
Education: Eastern KY U, BS
Committee Assignments:
Transportation



Charles L. Siler R-82

3570 Tackett Creek Road
Williamsburg, KY 40769
(606) 549-0900 (H)
Laurel, Whitley
Profession: Farmer, Retired Military
Officer
Education: Cumberland College; U of
Wisconsin, MA
Committee Assignments:
Appropriations & Revenue



Arnold Simpson D-65

28 West Fifth Street
Covington, KY 41011
(606) 261-6577 (O)
(606) 581-6521 (H)
Kenton
Profession: Attorney
Education: KY State U, BS; U of K, JD
Committee Assignments: Banking &
Insurance, Health & Welfare



Dottie J. Sims D-19

459 Violet Avenue
Horse Cave, KY 42749
(502) 786-2051 (O)
(502) 786-3948 (H)
Edmonson, Hart, LaRue
Profession: Tax Consultant
Education: Elizabethtown CC; Lindsey
Wilson College, AA
Committee Assignments: Banking &
Insurance



John Will Stacy D-71

PO Box 135
 West Liberty, KY 41472
 (606) 738-5483 (O)
 (606) 743-1516 (H)
 Menifee, Morgan, Rowan
 Profession: Businessman
 Education: Morehead State U, BS;
 Chase College of Law, JD
 Committee Assignments:
 Appropriations & Revenue, Rules,
 State Government, Transportation

**Kathy W. Stein D-75**

364 Transylvania Park
 Lexington, KY 40508
 (606) 225-4269 (O)
 (606) 252-1500 (H)
 Fayette
 Profession: Attorney
 Education: U of Virginia, BA; U of K,
 JD
 Committee Assignments: Health &
 Welfare, Judiciary.

**Jim Stewart R-86**

HC 76, Box 556
 Flat Lick, KY 40935
 (606) 287-3300 (O)
 (606) 542-5210 (H)
 Knox, Laurel
 Profession: Farmer
 Committee Assignments: Labor &
 Industry, Licensing & Occupations

**Gregory D. Stumbo D-95**

614 N. Lake Dr
 Prestonsburg, KY 41653
 (606) 886-1515 (O)
 (606) 886-9953 (H)
 Floyd
 Profession: Attorney
 Education: U of K, BA; U of L, JD
 Committee Assignments: Rules



Gary Tapp R-58

2600 Mt. Eden Road
Shelbyville, KY 40065

(502) 633-3180 (O)

(502) 647-1472 (H)

Bullitt, Shelby, Spencer

Profession: Store Owner

Committee Assignments:



Roger Thomas D-21

345 Elkins Road

Smiths Grove, KY 42171

(502) 563-4576 (O)

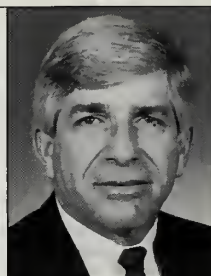
(502) 563-4582 (H)

Warren

Profession: Farmer

Education: Western KY U

Committee Assignments: Banking &
Insurance



James H. Thompson D-27

50 Crosier Road

Battletown, KY 40104-8022

(502) 422-2914 (O)

(502) 422-2034 (H)

Hardin, Meade

Profession: Pipefitter, Mechanical
Technician

Education: Western KY U

Committee Assignments:



Mark A. Treesh R-14

5735 Grady Court

Philpot, KY 42366

(502) 683-1388 (O)

(502) 729-9202 (H)

Daviess

Profession: CPA

Education: Purdue U, BS, MS

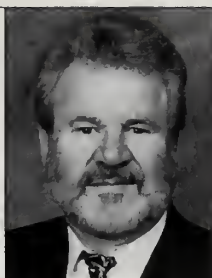
Committee Assignments:

Appropriations & Revenue



Johnnie Turner R-88

108 South First Street, PO Box 935
 Harlan, KY 40831
 (606) 573-7000 (O)
 (606) 573-6530 (H)
 Harlan
 Profession: Attorney
 Education: Union College, BS; U of
 KY, JD
 Committee Assignments: Labor &
 Industry

**Thomas J. Turner R-85**

65 Herrin Court
 Somerset, KY 42501
 (606) 274-5175 (H)
 Laurel, Pulaski
 Profession: Factory Employee, Farmer
 Committee Assignments: Labor &
 Industry, Transportation

**Ken Upchurch R-52**

PO Box 991
 Monticello, KY 42633
 (606) 348-8072 (O)
 McCreary, Pulaski, Wayne
 Profession: Company CEO
 Education: Eastern KY U, BA
 Committee Assignments: Banking &
 Insurance

**John F. Vincent R-100**

PO Box 2528
 Ashland, KY 41105
 (606) 329-8338 (O)
 (606) 325-0952 (H)
 Boyd
 Profession: Attorney
 Education: U of K, BA, JD
 Committee Assignments:
 Appropriations & Revenue,
 Judiciary, Transportation



Charlie Walton R-66

1663 Brierwood Court
Florence, KY 41042
(606) 371-1943 (H)
Boone
Profession: Teacher
Education: Eastern KY U, BS;
Northern KY U, MA
Committee Assignments:



Jim Wayne D-35

1280 Royal Avenue
Louisville, KY 40204
(502) 451-8262 (O)
(502) 456-4856 (H)
Jefferson
Profession: Therapist
Education: Maryknoll College, BA;
Maryknoll School of Theology, MA;
Smith College School of Social Work,
MSW

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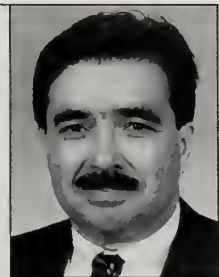
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2000

HOUSE OF DELEGATES/ BOARD OF TRUSTEES LEGISLATIVE POLICIES

The KMA House of Delegates and the Board of Trustees have adopted policies on the following topics.

Any Willing Provider

Statutory Definition: "Health care benefit plans shall not discriminate against any provider, located within the geographic coverage area of the health benefit plan, willing to meet the terms and conditions for participation established by the health benefit plan." KMA supports retention of this statute.

Animal Research

KMA supports education of the public regarding the benefits of the use of animals in biomedical research; acknowledges its commitment to the humane treatment of animals used in biomedical research and the pursuit of alternative research models where appropriate; supports a minimum criminal penalty of a felony 4th class, for unauthorized removal of research animals and/or willful damage to research facilities and/or research projects.

Abortion

After the stage of viability, termination of pregnancy must be limited to those situations in which the life of the mother is jeopardized or a proven fetal anomaly exists. Abortion on demand is discouraged at any time; any live infant must be accorded the same rights and the same care that would be given to an infant delivered by more traditional means; the practice of using fetuses as experimental material is condemned; no hospital, clinic, institution, or any other facility in this state should be required to admit any patient for the purpose of performing an abortion nor required to allow the performance of an abortion; no person should be required to perform or participate directly or indirectly in an abortion procedure. No hospital, governing board, or any other person, firm, association, or group should terminate the employment or alter the position of, prevent or impair the practice or occupation of, or impose any other sanction or otherwise discriminate against any person who refuses to participate in an abortion procedure.

Advanced Directives: Wards Of The State

Allow decisions to be made regarding advance directives

and termination of inappropriate medical intervention in patients who are wards of the state, on a case by case basis.

Advanced Registered Nurse Practitioners

KMA supports the joint collaborative practice of physicians and ARNPs. ARNPs should be permitted to prescribe non scheduled drugs under written protocol and a formulary approved by the supervising physician and appropriate licensing authorities within closely defined geographic areas. ARNPs must complete established pharmacological prerequisites and maintain continuing education in the use of prescribed substances. The KMA opposes any effort by ARNPs to prescribe narcotics, opposes independent practice of ARNPs granted prescriptive privileges, and opposes any law or regulation that undermines the authority of physicians to determine patient care. The Kentucky Board of Medical Licensure (KBML) should develop regulations restricting the number of ARNPs with which a physician may have collaborative agreements. Physicians should individualize collaborative agreements based on the need of their patients and practice. KBML should develop criteria for collaborative agreements that safeguard patient care, including experience and educational background of the ARNP, appropriate referral patterns, quality assurance, and continuing education.

Alcohol

Warnings Against Use Of Alcohol During Pregnancy

Warning signs should be posted in all places where alcohol is sold that drinking alcoholic beverages during pregnancy can cause birth defects.

Driving Under The Influence Of Alcohol/Drugs

KMA supports lowering the allowable blood alcohol content (BAC) from 0.10 to 0.05. The KMA supports stricter enforcement of penalties for those convicted of driving under the influence of alcohol or drugs. Although less vogue than drug abuse, the drinking driver presents a much more serious threat to life and health in Kentucky.

Alcohol Use In Water Sports

The General Assembly should study the potential risks of unsafe operation of water jet skis, boats, and alcohol use in water sports and require adequate education and operation prior to use of such vehicles.

Brain Death

A physician in the exercise of his professional judgment may declare an individual dead in accordance with accepted medical standards. Such declaration may be based solely on an irreversible cessation of brain function including the function of the brain stem.



2000

Blood Alcohol Content (BAC)

Allowable blood alcohol content (BAC) of Kentucky drivers should be reduced from 0.10 to 0.05.

Boat Safety

Legislation and regulations should be adopted to regulate water jet skis, boats, and alcohol use in water sports.

Bicycle Helmets

The KMA supports the enactment of legislation requiring bicycle riders to wear helmets while on streets or roadways.

Child Restraints

The KMA endorses the concept of mandatory child restraints in automobiles.

Continuing Medical Education (CME)

Mandatory Requirement

The KMA calls on all physicians to participate in CME in a formal manner and supports as a condition of Licensure, that physicians obtain 60 hours within each three-year period. Of the 60 hours, 30 must be in Category 1 credit, and 2 hours must be obtained from a CHS approved HIV/AIDS training course.

Disease/Topic Specific CME

The KMA opposes mandated "disease" and "topic-specific" CME and urges repeal of any and all statutory requirements for CME of specific diseases.

Certificate Of Need (CON)

Physician Offices

The KMA supports the preservation of the private physician's office exemption from CON and defends the control of physicians and their offices to remain with the Kentucky Board of Medical Licensure and its statutory authority over the practice of medicine.

Mobile Units Operated By Physicians

KMA opposes efforts to extend regulatory power over mobile units operated by physicians.

Threshold Requirements

Private offices and clinics of physicians and other practitioners of the healing arts should be exempt from CON requirements. Exemption includes, but is not limited to, licensure, supervision, regulation, or control regulated by the state, except as physicians propose to purchase equipment which costs exceed \$250,000.

Other Entities Covered By CON

KMA opposes exemptions based on geography, population, and number of acute hospital beds. KMA supports the retention of CON on nursing home beds.

Committee On State Legislative Activities (COSLA) Operating Procedures During The Kentucky General Assembly

- (1) All state legislative proposals are to be coordinated by and channeled through COSLA.
- (2) The composition, authority, and function of the Quick Action Committee (QAC) are retained.
- (3) The composition, priority, manner, and time of introduction of state legislative proposals are to be left to the discretion of the Chair of COSLA and the QAC. The House of Delegates, recognizing the enormous task KMA faces as dramatic transformations are proposed in the health care delivery system which require immediate decisions, authorizes the QAC, in consultation with the KMA Executive Committee when indicated, to set legislative policies determined to be in the best interest of the Association, and to represent the Association in all matters. The Chair of COSLA shall keep membership of KMA, the House of Delegates, and the Board of Trustees fully informed as to the progress of legislative deliberations and provide to the membership details of KMA's plans and recommendations on becoming involved. The President of KMA is authorized to call emergency meetings of the KMA Board of Trustees as necessary, and special sessions of the House of Delegates in accordance with the Constitution and Bylaws if appropriate.

Campaign Financing

KMA opposes public financing of federal campaigns and limits on political action committee activities. Such control would limit participation in the political process and the political education benefits afforded by PACs.

Capital Punishment

KMA neither supports nor opposes the death penalty, recognizing that capital punishment is the personal moral decision of the individual. Physician participation in executions, except to certify cause of death, provided that the condemned has been declared dead by another person, is a serious violation of medical ethics. The KMA opposes any requirement for physician participation in execution except to certify death.

Commissioner Health Services

The Commissioner of the Bureau for Health Services should be a licensed, experienced, and qualified physician.



Credentialing

Quality improvement shall remain the primary purpose of the credentialing process involving physicians. The KMA opposes economic credentialing and political interference in the physician credentialing process.

Data Collection

The KMA supports repeal of provisions which require the submission of data from physicians offices or clinics.

Death

Death Penalty

(see Capital punishment)

Definition Of Death

Legislative and judicial intrusion into circumstances surrounding the possible death of critically or terminally ill patients should be kept at an absolute minimum. Decisions concerning the care of such patients should be left to the patient, their doctor and the patient's relatives in accordance with time honored customs. The patient's wishes in these matters should be of utmost importance and should be respected whenever possible. Death shall be determined by the clinical judgment of the physician using the necessary available and currently accepted criteria.

Model Uniform Death Act

KMA recommends the AMA model uniform death act. "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

Death Certificates

The KMA urges physicians to promptly sign death certificates.

Driving Under The Influence

(see alcohol or BAC)

Drug Abuse

KMA will do everything within its power to lead the fight against drug abuse in Kentucky, not only in the case of abuse of amphetamines, but in the over-use, misuse, or abuse of any dangerous drug.

Do Not Resuscitate (DNR)

KMA supports a uniform, coordinated, and rational approach with respect to the terminally ill patient who does not wish to be resuscitated or to receive extraordinary life-prolonging treatment in the pre-hospital environment. Physicians should be aware of the Kentucky

EMS DNR order form and how it is to be used to minimize potential misunderstandings among physicians, EMS personnel, and affected family members. KMA supports the patient's right of self determination, as well as the health care professionals who follow such directives.

Dual Licensure Of Hospital Beds

The KMA endorses efforts of Kentucky Hospital Association in addressing the issue of dual licensure of hospital beds in Kentucky.

Education

Health Education

The KMA recommends that health education be taught to all students from Kindergarten to 12th grade, and affirms support for "parenting and family life skills education" curriculum in public schools.

Sex Education

KMA strongly supports sex education in schools, beginning in grades 5-7, recognizing that Kentucky has a very difficult and major problem with young adolescent pregnancies.

Physical Fitness Education

The KMA encourages uniform health education and physical fitness proficiency testing in all schools.

Sports Physicals

All physical examinations for participation in school-sponsored sports should be done under the supervision of a physician.

Anabolic Steroids

Students should be warned of the dangers of the use of anabolic steroids.

Athletic Trainers

The KMA encourages the State Board of Education where and when possible, to recommend to local boards of education the appointment of certified athletic trainers to work with physicians in the important area of health and supervision of athletes.

Ultraviolet Radiation Education

The KMA urges the State Board of Education to include in the curriculum appropriate information for teachers to educate students about hazards of ultraviolet radiation and tanning parlors.

Eye Care

The KMA recommends that legislation be enacted to require referral by nonphysicians to physicians, any person identified as an individual with suspected medical or surgical eye disease or medical conditions involving pathology of the eyes.



Euthanasia

The policy of the KMA concerning death and dying is totally opposed to any form of "active euthanasia."

Fireworks

The KMA supports the ban of all fireworks with the exception of approved professional displays.

Fees

Fee Setting

The KMA is opposed to governmental rate setting of physician fees and imposition of global budgets.

Inequitable Reimbursement

The KMA opposes payment differentials to physicians and hospitals based on geographic location. In the process of instituting single, equitable, statewide reimbursement schedules, insurance companies should not diminish any present reimbursement schedules.

Credit Cards

The use of a bank card in connection with the payment of larger fees—which might normally be paid in installments, is not to be encouraged. All members of the Association are expected to continue the traditional practice of permitting patients of limited means to pay relatively large fees in installments without interest or carrying charges.

Gag Clauses

KMA supports efforts to ban "gag" and "hold harmless" clauses from contracts between managed care entities and physicians. All physicians are urged to consult with legal counsel prior to contracting with a managed care entity to prevent the imposition of unfair liability upon the physician.

Pregnancy Options Counseling

KMA opposes intrusion into the doctor-patient relationship by means of a "gag rule" limiting patient counseling in federally funded family planning clinics.

HIV Testing

Pregnant Women

The KMA recommends HIV testing of all pregnant women.

HIV And Physicians

The KMA opposes mandatory HIV testing for Physicians.

HIV Reporting And Confidentiality

KMA supports the enactment of legislation to: Prohibit discrimination against all persons infected with or perceived to be infected with HIV. Supports anonymous testing for HIV positivity where available. Supports requirement that confirmed HIV positivity is reported to the

Department of health services and the local health department including at least the person's date of birth, race, sex, risk factor(s) and county of residence. Identification can be by patient's name and address if patient agrees, but must include as a minimum, a code assigned to the individual by the reporting physician which will always be the same for a given patient, but which in and of itself, will not identify the patient (such as patient's initials). Health workers are informed of a patient's positive HIV status if they are directly responsible for care of that patient.

Consent For HIV Testing

KMA supports legislation to provide that consent for treatment by a physician or a hospital shall also include the possibility of testing for HIV if deemed appropriate by the physician(s) involved in the care of that patient.

Release Of Medical Information

KMA supports the requirement that a positive HIV test result (confirmed Western Blot or equivalent) be deemed a Sexually Transmitted Disease (STD). KMA supports the authorization of the release of medical information to all medical personnel involved in the treatment of a patient who has a STD.

High Risk Newborns

(See Medicaid: High risk newborns)

Health Departments

Role Of Health Departments

The KMA affirms its support of local Boards of Health to determine the need of local citizens in public health measures, and urges its members who serve on local boards to actively participate. Discussions should be held on the local level between hospitals, health departments, and physicians to define the future role. The KMA opposes plans to provide routine unrestricted medical services through health departments, acute ambulatory services, and solicitation of private patients and provision of routine medical services by health departments. Health Departments should limit their endeavors to public health measures and not to the delivery of primary care.

Health Insurance

Standard Claim Form

KMA supports a standard, mandatory, and common claim form for all insurers.

Freedom Of Selection

KMA opposes restrictions on citizen's freedom of choice in selection of health insurance.

Obstetrical Care Coverage

The KMA reaffirms the patient-physician relationship



and the ability of the physician to do what is in the best interest of the patient. In the absence of definitive empirical data, discharge following delivery should be determined by clinical judgment of physicians rather than health insurance guidelines. The KMA supports legislation that prevents third-party payers from interfering, by refusing to pay for care, with physicians' clinical judgment regarding patient care, including timing of discharge.

Insurance Coverage Of Medical Services

KMA supports payment for medically necessary services by insurers/payers based on the appropriate care of the patient. Decisions regarding insurance coverage of medical services should be considered separately for each service in question in the context of patient need and the physician's medical judgment.

AMA CPT Codes

The KMA supports statewide use of AMA CPT coding by insurance carriers.

Assistant Surgeons

The attending Surgeon is the individual best qualified to determine whether or not an assistant surgeon is needed. The physician serving as the assistant surgeon should be compensated fairly.

Hold Harmless Clauses

(see gag clauses)

Primary Care Physicians' Treatment Of Depression

KMA opposes reimbursement policies not paying primary care physicians for the outpatient treatment of depression or other mental health diagnosis.

Helmet laws

Motorcycle Helmets

Mandatory motorcycle helmet laws should be enacted.

Bicycle Helmets

KMA supports legislation requiring bicycle riders on Kentucky roads and streets to wear approved protective helmets.

Hospital Bed Dual Licensure

(See Dual Licensure of hospital beds)

Indigent Care

KMA recognizes that approximately 400,000 Kentuckians are uninsured. The Association proposes a plan based on Medicaid using the KenPAC approach, which offers basic medical services. Funding for the program may be obtained by taxes from various sources. The KMA supports additional funding for prenatal and pediatric care.

Indigent Medical Care Funding

Funding for indigent medical care should be obtained through the broadest possible spread throughout society as a whole. The KMA encourages State Legislators to study the statewide problem of indigent medical care and to assure adequate funding for the continued financial stability of the state teaching hospitals.

Insurance Commissioner

KMA opposes the concept of an "elected" Insurance Commissioner.

Involuntary Service Requirement

KMA opposes any legislative proposal that institutes an involuntary service requirement for physicians trained in Kentucky.

Joint collaborative practice with ARNP/PA

KMA supports the joint practice of physicians, Physician Assistants (PAs), and Advanced Registered Nurse Practitioners (ARNPs). The KMA supports legislation to permit PAs and ARNPs to prescribe nonscheduled medication under written protocol with the collaborating physician. There should be well-defined limits on the numbers of PAs/ARNPs a physician may supervise within closely defined geographic areas.

KENPAC

The KMA endorses the KENPAC program as outlined by the Cabinet for Health Services for Medicaid recipients. If appropriate, KMA will oppose by reasonable lawful means, any Medicaid managed care program proposed to supplant KENPAC unless improvement over KENPAC would result.

Laser Surgery

The use of laser equipment in surgery should be defined as the practice of medicine. Surgery is defined as any invasive procedure by any means which alters, penetrates, changes, or violates in any way human tissue, and includes preoperative and postoperative care for surgery. Appropriate exemptions should be established for dentists and podiatrists to the limit of their licenses, and exceptions granted to Nurses and other health personnel to perform routine patient care activity such as injections, routine testing, etc, as prescribed by the attending or consulting physician. The KMA opposes any legislation or administrative proposal to permit nonphysicians to perform laser surgery.

Listening Devices

KMA supports legislation to restrict the use of personal



listening devices by joggers and bicycle riders using public thoroughfares.

Lap Shoulder Harness

KMA supports mandatory use of lap-shoulder belt systems in Kentucky motor vehicles

Medical Directors

Medical Directors of insurance companies, health maintenance organizations, and managed care networks serving patients in Kentucky should be required to be licensed in Kentucky under jurisdiction of the Board of Licensure. Managed care organizations and employees who make decisions which result in patient injury should be held legally responsible for their decisions.

Medicaid Regional Partnerships

The Cabinet for Health Services should limit implementation of privatization methodologies to one, or perhaps two, pilot projects. Based upon reported activities, it appears such pilot projects are centered in regions 3, 5, or both. The KMA suggests that while other areas of the state may wish to develop an infrastructure capable of supporting a managed care partnership, actual implementation of this strategy should be held in abeyance until pilot projects clearly demonstrate their value to the Commonwealth.

Medicaid

Reimbursement/funding

KMA actively promotes a reasonable reimbursement rate for Medicaid providers, and stands for adequate and broad-based state general funding for the Medicaid program. KMA is opposed to shifting Medicaid funds to balance the general budget.

High Risk Newborn

All high-risk newborns eligible for Medicaid should be followed by their physicians, their designees, and/or visited by a public health nurse to ensure PKU testing; metabolic screening; access to a primary care provider; infant immunizations; access to the WIC program where indicated; implementation of application for newborn under Medicaid; and repeat pregnancy education.

Privatization Of Medicaid

Any substantial revision structure of Medicaid must retain assurances that the plan be able to enlist enough physicians so that care and services are available to the general population. If proposed revisions are not in the best interest of patients and physicians appropriate legal, judicial, legislative, or administrative actions will be taken.

Equitable Payments To All Specialties

Reimbursement methods should not discriminate against

any class or specialty of physicians. KMA urges CHS to examine the Medicaid reimbursement policy, and this policy should reflect reimbursement levels proportionate to charges and level of skill and training, regardless of physician location or specialty.

Mandated Service Requirement

(see involuntary service requirement)

Medical Records/X-RAYS

Medical records and X-rays are the property of physicians. Copies of records and X-rays should be available for an appropriate fee that permits providers to recover administrative and actual copying expenses. KMA supports repeal of the requirement that physicians provide free copies of medical records. However, medical records should be forwarded to a different or new attending physician upon proper request.

Medical Laboratories

Medical laboratories operated by a licensed physician or group of licensed physicians, solely and exclusively in connection with the diagnosis and treatment of their own patients, should be exempt from state provisions governing laboratories. If any referred work is received or performed by such medical laboratories, all provisions of the act should apply.

Medical Waste

KMA condemns the disposal of hazardous medical waste in any fashion which might be harmful or dangerous to humans, animals, or the environment. Guidelines and/or regulations governing the disposal of hazardous medical waste materials should be developed.

Medical Education Funds

KMA opposes reallocation of human, financial, and academic resources currently available for medical education toward an additional allopathic, osteopathic, public or private medical school.

Mental Health Benefits

KMA supports the provision of benefits for emotional and mental illness under all governmental and private insurance programs which are equivalent in scope and duration to those benefits provided for other medical or physical illnesses.

Medicare Supplement Insurance

Medicare supplement policies should be standardized, and consistent with model regulations developed by the National Association of Insurance Commissioners. All



supplements should pay all or none of the Part A deductible, and pay at least 20% of Part B provider copayments, regardless of location of care. HMOs should not be exempt from these provisions.

Managed Care

Managed care is designed to reduce costs and maintain quality of medical care. A system should be developed to monitor managed care and assure patients' decreased costs, along with quality of medical care.

Medical Examiners

KMA supports the expansion of the medical examiners system throughout the state of Kentucky. The Department of Justice should formulate a plan to improve medical/legal death investigation in the Commonwealth to include appropriate state fiscal support to implement such a plan.

Motorcycle Helmets

A mandatory motorcycle helmet law should be enacted.

Nursing Home Beds

KMA urges the Kentucky General Assembly to appoint a task force to study the issue of the limited supply of extended beds in Kentucky.

Non Physician Practitioners

KMA opposes additional licensure of health care workers. Certification of health care personnel should be considered on a case-by-case basis. Enhancement of practice acts by nonphysician practitioners, through legislative fiat rather than education, is inappropriate.

Optometrists

KMA opposes legislation allowing optometrists to act or serve as primary care providers in performance of the practice of medicine, surgery, or laser surgery. The KMA opposes any legislation granting optometrists the right to prescribe or apply medications, or to diagnose disease or injury, or to diagnose the absence of disease or injury.

Ophthalmologists

Ophthalmologists shall be regarded as comprehensive (primary, secondary, and tertiary) eyecare providers.

Patient Right Of Determination

KMA supports legislation or regulation that protects "patient's right of determination" and the activities of health care professionals who follow such directives.

Provider Tax

The KMA opposes a provider tax.

Provider Sponsored Networks

The KMA supports the establishment of provider sponsored networks and recommends that financial solvency reserves be different than required of HMOs and other risk-bearing insurance entities.

Primary Care Physicians

Obstetricians

Obstetricians should be regarded as primary care physicians to their obstetrical patients during the perinatal period.

Ophthalmologist

Ophthalmologist shall be regarded as comprehensive (primary, secondary, tertiary) eyecare providers.

Patient Protection Provisions

The KMA supports the priority of patient welfare in all managed care programs and the rights of patients to be advised. The KMA advocates state laws that provide for patient protection and physician fairness in managed care organizations.

Rights Of Patients In Managed Care

- Services covered or excluded under a health plan printed in easily understood language.
- Requirements for preauthorization of physician services or post treatment review, which may lead to denial of coverage.
- Financial arrangements which would limit services, restrict referrals, or establish incentives not to deliver services.
- Information in an understandable format that states the percentage of premium dollars spent on direct patient care.
- Patients ability to continue treatment with their provider of choice during the period of enrollment.
- Patients ability to receive necessary emergency services and assurances that the plan will provide reimbursement for such services regardless of the provider's participating status in such plan with no post treatment denial.
- A grievance and appeal procedure to resolve disputes over medical necessity, appropriateness of care decisions and coverage issues.

Patient Protection And Physician Fairness

In Managed Care

- Permit physicians to negotiate with managed care organizations, as appropriate.
- Provide for formal practicing physician input in the development and refinement of medical policies, includ-



ing credentialing, utilization review, quality assurance, and benefit package.

- Require disclosure of all participation requirements and selective contracting decisions, and disclosure of reasons for denial or deselection.
- Provide enrollees and participating physicians with the opportunity to complete a "report card" at regular intervals regarding the quality of service rendered.

Point Of Service

KMA advocates a point-of-service feature requirement in all managed care plans which have a closed panel.

Public Financing Of Campaigns

(See campaign financing)

Prescription Drugs By Mail

The KMA should take reasonable steps to prevent the prescribing of large quantity mail orders for scheduled drugs or other drugs with abuse potential. The KMA should take steps to make the detrimental aspects of large quantity mail order prescriptions known to the purchasers and users of these drugs in an attempt to diminish this activity.

Patient Diagnosis On Prescriptions

The KMA opposes any effort to require patients diagnosis on prescriptions. Such proposals create numerous concerns, including confidentiality.

Physician Assistants (PA)

KMA supports the joint collaborative practice of physicians and physicians assistants in which PAs are supervised by licensed physicians. The KMA endorses legislation permitting PAs to prescribe, dispense, and order nonscheduled medications in accordance with the discretion and responsible oversight of the supervising physician. Health care services provided by the PA should be reimbursed to the supervising physician. The KMA urges the CHR to reimburse PA services rendered to Medicaid patients.

Physician Extenders

KMA supports certification of physician extenders by the Kentucky Board of Medical Licensure. The Board shall have responsibility of determining the qualifications of all such personnel and the parameters of practice on an individual basis to licensed physicians who may utilize such personnel.

Physician Fees

(See fees)

Rate Setting

(See fees)

Political Action Committees (PAC)

(See campaign financing)

Rape Victims

KMA supports legislation that would prohibit the news and print media from making public the names of rape victims.

Respiratory Therapists

KMA supports the mandatory certification of respiratory therapists under the auspices of the Division of Occupations and Professions.

Riding in Rear Of Open Trucks

KMA supports legislation prohibiting all persons not of the age of majority in the Commonwealth from riding in the rear of open trucks.

Seat Belts

KMA supports the mandatory use of seat belts. All passengers in moving vehicles should be required to use safety belts.

Sex Education

(See education)

Statewide Fee Schedule

(See fees)

Telemedicine

The KMA recommends that in the best interest of the health and safety of the citizens of Kentucky that all non-resident physicians practicing telemedicine in Kentucky be required to have a full and unrestricted license to practice medicine in this state.

Tobacco

The KMA recommends:

- All Hospitals and clinics should prohibit smoking within their buildings.
- Designation of all restaurants as smoke-free, or at least the creation of adequate nonsmoking area.
- Oppose use of tax dollars to finance efforts, including lawsuits, aimed at overturning or postponing FDA regulations re: tobacco.
- Encourages physicians to intensify educational efforts directed to patients on the deleterious effects of tobacco use.
- Encourages the Kentucky General Assembly to increase its attention to the serious health problem of tobacco product use and the trend of teenage smoking.



- Increased fines for illegal tobacco sales to minors.
- Allow standard law enforcement agencies to enforce sales restrictions for children.
- Permit local communities to pass more stringent laws if they feel appropriate.
- Legislation prohibiting the sale of tobacco to individuals under 18 years of age.
- Opposes use of billboards or other mediums which advertise tobacco products visible from school property.
- Enactment of a clean indoor air standard, applicable to all public buildings and all buildings open to public access, which restricts smoking to designated areas which are separately vented to the outside.
- Require all school districts to ban smoking and use of tobacco products from all school buildings, property, and school sponsored events involving students.
- Ban the sale of tobacco products in vending machines except to areas off limits to minors or operated with tokens which can be acquired only by adults.
- Include tobacco use rates and tobacco related knowledge levels as evaluation criteria for schools under the framework of education reform.
- Ban tobacco company sponsorship of athletic events in which youth are involved.
- Provide that in order to sell tobacco products, a retailer must have a license (similar to a liquor license) which can be revoked for sale to minors.
- Ban distributions of free tobacco product samples altogether as part of retail license requirements.
- Restrict tobacco advertising to black and white printed text without pictures (the tombstone law), if permissible under federal law.
- Repeal the "smokers' rights" provisions which forbid consideration of smoking practices as a legitimate factor in employment decisions.

Taxes

Provider

The KMA opposes the provider tax.

Cigarette/Tobacco

KMA supports increases in the tax on tobacco in order to lower the number of new teenage smokers. Funds raised through increased tobacco tax should be used to fund health care in Kentucky, and to fund the development of agricultural alternatives to growing and processing of tobacco and tobacco products.

Tax Free Income For Services To Medicare/Medicaid Patients

KMA supports legislation exempting physicians' income

earned from providing services to Medicare and Medicaid patients in rural and underserved areas from federal and state income taxes.

Tort Reform

The KMA supports a Constitutional Amendment to permit the General Assembly to place a limitation on non-economic awards.

Ultraviolet Radiation

(See education: Ultraviolet radiation)

Uninsured

(See indigent care)

Vision Testing For Drivers License

KMA supports periodic retesting of vision, preferably at the time of each quadrennial drivers license renewal. The KMA should carefully consider any legislation regarding the requirement for such retesting and take action as appropriate.

Water Sports And Safety

(See alcohol use in water safety)

Wards Of The State

(See Advanced Directives: Wards of the state)

Workers Compensation

Kentucky physicians offices and clinics employ approximately 40,000 Kentuckians and KMA is mindful of the increasing costs of workers compensation insurance. Physicians are equally concerned with their patients and access to quality medical care and appropriate benefits when injured on the job. Worker Compensation laws should be fair and equitable and strike a delicate balance which should be beneficial in the long term to both employee and employer.

X-rays

(See Medical Records, X-Rays)

Becoming a Doctor

- It takes 12 years, often longer to become a doctor, with 4 years of college, 4 years of medical school, and 3-5 years residency
- The average physician graduates medical school with \$150,000-\$250,000 in student loan debt



LEGISLATIVE TERMS AND DEFINITIONS

The following terminology may be helpful to you in your involvement with legislative process.

Acts — the volume of bills enacted at one session; published by Legislative Research Commission

Adjourn (motion to) — an action to discontinue proceedings for the day; a privileged motion non-debatable, not subject to amendment, and requiring for its adoption the assenting votes of a majority of the members present and voting

Adjournment Sine Die — adjournment "without a day"; this action ends a session, since no time is set for reconvening; this type of adjournment may occur at any time during a session

Administrative regulation — an enactment of law by an executive-branch agency or department, under authority granted by the General Assembly

Administration bill — legislation introduced at the behest of an executive-branch agency or department, usually sponsored by the majority floor leader

Adoption — approval or acceptance; usually applied to resolutions or amendments

Amend (motion to) — an action to modify the contents of a bill or question under consideration; the motion to amend is in order at any time prior to final passage, unless the previous question has been ordered

Amendment — any alteration made or proposed to be made in a bill, motion or clause thereof, by adding, substituting or deleting

Committee — a group of legislators, usually members of the same house, assigned to consider some issue or question and submit a report on its recommendations for action by the body which created it

Committee amendment — an amendment to a bill which is attached to the bill by a committee and made a part of the committee's report on the bill

Conference Committee — a joint committee of senators and representatives directed to reach agreement on legislation on which the two houses are unable to agree

Committee, interim joint — a committee composed of all members of a Senate standing committee and all members of a House standing committee, which meets between sessions as a subcommittee of the Legislative Research Commission

Committee substitute — a bill offered by a committee in lieu of a bill it has considered; technically, the committee substitute is an amendment to the original bill

Companion bill — a bill which is identical to a bill having been introduced in the opposite house

Concur — action by one house to agree to modifications of its legislation by the opposite house

Consent calendar (or consent orders) — a list of bills having had one (or two) reading(s), and on which members in attendance are presumed to vote yes unless they indicate a negative vote prior to the call of the roll

Constitutional majority — one more than half of the members of deliberative body

- Co-sponsor** — a sponsor of a bill or resolution who is not the principal sponsor
- Effective date** — the date on which a legislative measure begins to function as a part of the law; in Kentucky, most legislation becomes effective 90 days after sine die adjournment
- Emergency clause** — provision in a bill that it become effective immediately upon approval by the governor rather than the 90 days after adjournment
- Enrollment** — the act of comparing a printed bill to be transmitted to the governor with the original; introduced bill with all amendments, so as to ascertain their identical form
- Floor** — the area of a legislative chamber which is occupied by the members and staff of the body
- Floor amendment** — an amendment filed with the clerk to be considered on third reading of the bill to which it has been filed
- General orders** — a list of measures eligible for debate, amendment and voting on a given day, without reference to a particular time of day or place in the order of business
- Hopper** — colloquial name given the repository for bills awaiting introduction; in Kentucky such bills are filed with the clerk
- House** — one body of deliberation in a legislature; customarily a shortened name for the House of Representatives
- Interim** — the period of time between sessions of a legislature
- Introduction** — the presentation of a bill or resolution to the legislative body for its consideration
- Joint sponsorship** — a procedure in the Kentucky House of Representatives whereby several members may sponsor legislation without one being a "principal" sponsor, and each bearing equal responsibility as endorsing the measure
- Kentucky Revised Statutes** — the official title of statute law in Kentucky; each bill creates, amends, or repeals a section of the KRS
- Lay on the clerk's desk (motion to)** — an action to place a measure in a position of temporary postponement
- Lay on the table (motion to)** — an action to declare a measure defeated
- Majority caucus chairman** — a member affiliated with the majority party, who is responsible for convening the caucus of his party and presiding over its deliberations
- Majority floor leader** — a member affiliated with the majority party, designated to act for the party during the proceedings on the floor
- Majority party** — the political party whose members occupy at least one more than half of the total membership of the body
- Majority whip** — a member affiliated with the majority party, designated to assist the floor leader during proceedings on the floor
- Passage** — the approval of a bill or resolution by way of an affirmative vote
- Postpone indefinitely (motion to)** — action to prevent consideration of a measure for the remainder of the session, unless a constitutional majority sustains a motion to reconsider the matter
- Postpone a fixed time (motion to)** — to defer consideration of a question until a time specified in the motion
- Prefiled bill** — a bill filed prior to the session, for public discussion and printing
- President** — the presiding officer in the Senate



- President pro tempore** — the Senator, elected by the Senate, chosen to preside in lieu of the President when such officer is absent or unable to preside
- Quorum** — the number of members of a legislative body which must be present to transact business
- Reading** — each bill to be enacted in Kentucky must have three readings, at length, in each house
- Recommit (motion to)** — action to send a measure to committee after it has been previously reported
- Reconsider (motion to)** — action to re-take a vote; the motion may be offered only by a member having voted previously on the prevailing side
- Refer** — to send a measure or question to committee
- Resolution, concurrent** — expression of opinion or request by both houses of a legislature, without the force of law
- Resolution, joint** — to enact matters of law not to be made a portion of the statutes
- Resolution, simple** — expression or request by one house
- Revision** — the process of inserting the enactments of a session into existing statute law
- Roll call** — to determine a vote on a question by taking of names in favor and opposed
- Section** — a division of a bill or statute, separated according to topic covered or action taken
- Session, extraordinary** — a session convened by call of the Governor
- Session, regular** — a session convened on a regular basis by way of constitutional provision as to its date and length
- Simple majority** — a majority of those voting on a question
- Speaker** — the presiding officer of the House of Representatives
- Speaker pro tempore** — the member of the House of Representatives selected to preside in the absence or inability of the Speaker
- Special order** — an action predetermined to occur at a specific time on a specific date
- Stopping the clock** — an occasional tactic on the final evening of a regular session whereby the proceedings continue into the following day, with the clock and journal continuing to indicate occurrences of action of the preceding day
- Sunset legislation** — a law requiring termination of a particular agency or program on a predetermined date, unless justification for continuance is presented to the legislature prior to such occurrence
- Suspend the rules** — action to negate the application of a particular rule of procedure; the rule and purpose must be stated in the motion to suspend
- Veto** — rejection of an enactment without authority to modify; usually the prerogative of the Governor
- Veto override** — authority of the legislature to overturn a rejection of legislation by the Governor
- Voice vote** — a method of voting whereby only a vocal response to a question is indicated
- Vote** — a decision on a question by a member of a deliberative body, either affirmative or negative
- Withdraw** — to recall, remove or delete a question from consideration

PATIENT PROTECTION

KMA's primary focus during the 1998 session was to enact Patient Protection and Provider Fairness legislation in accordance with House of Delegates directives. KMA elected to include Patient Protection/Provider Fairness legislation within HB 315, the DeWeese-Damron proposal to reform health insurance, rather than presenting the proposal as a separate and distinct bill. Based on reports from other states and AMA's experience with the 1997 Congress, this turned out to be the correct decision. In 1997 Chambers of Commerce, business, and the managed care industry coalesced to defeat these proposals in Congress and several states.

HB 315 included the following Patient Protection/Provider Fairness components:

Patient Information from Insurers

Requires all insurers to state, in writing, the conditions, terms and information, such as appeals mechanisms, prior authorization procedures, restrictions on access to providers, and other review mechanisms imposed by the insurer.

Financial Disclosure to Patients

Managed care plans must include lists of physicians, by county, specialty and hospital affiliation, and disclose any financial incentives from the managed care plan and other appropriate consumer information.

Adequate Staffing

All managed care plans must have sufficient numbers of primary care, specialist providers, and facility access for their enrollees. Telephone access to the plan must be available, and reasonable standards must be established for waiting times to obtain appointments.

Choice of Primary Care Provider

Adequate choices of primary care must be available. Patients must be allowed to choose their primary care provider from the plan list.

Use of Specialists as Primary Care Provider

Plans must permit patients to use specialists as a primary provider when medical conditions warrant.

Prudent Layperson Definition of Emergency

Emergency care must be available without prior authorization, and the definition of "emergency" must be defined in terms a "prudent layperson" understands.



Prohibit Gag Clauses

Plans are prohibited from limiting providers' disclosure to patients of medical conditions or treatment options.

Once Prior Approval is Granted Claim can only be Rejected in Cases of Fraud

When prior approval has been obtained, coverage shall not be retrospectively denied unless the approval was based upon fraudulent, materially inaccurate, or misrepresented information by either the patient or the provider.

Requires Managed Care to Comply with "Do Not Substitute" Provision

When a physician determines that generic substitution of a pharmaceutical product is medically inappropriate, the pharmacist shall prescribe the product the physician determines medically appropriate with the indication "do not substitute." No substitution shall be made without the physician's approval.

Significant Trends: Erosion of Competition among Insurers

- Intense consolidation in health financing over last 5 years
- Since 1994, mergers and acquisitions have reduced 18 largest health plans down to only 6.

**Market Consolidation =
Reduced Competition and Choice
Patients Lose**

PROVIDER FAIRNESS

De-selection/Termination of Provider

Each plan must have a policy governing de-selection or termination of a provider from a network. If requested by the provider, the network must provide a reason for termination and hold a hearing within 30 days.

Medical Director

The Medical Director must be licensed in the state in which he or she is employed, and is responsible for treatment policies, protocols, quality assurance activities, and utilization management decisions of the plan. Decisions to deny, reduce, or terminate a health care benefit or to deny payment for a health service because that service is not medically necessary, shall be made by a physician.

Prohibit "Most Favored Nation" Clauses

Insurance contracts cannot contain a "most favored nation" provision unless the Commissioner determines the market share of the insurer is nominal.

Prohibit Discriminatory Payments to Providers

Providers under the guaranteed acceptance program (GAP) shall be reimbursed at rates that are no less favorable than the rates paid to the comparable providers for services delivered to enrollees who do not have a high-cost condition.

Point of Service Option

Every plan must provide "point of service" or out-of-network benefits to every contract holder that allows a covered person to receive covered services from out-of-network providers without having to obtain a referral.

Any Willing Provider

Health insurers cannot discriminate against any provider who is located in the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation established by the health insurer, including Medicaid and Medicaid Partnerships.

Insurer Accountability

Insurer accountability for limiting coverage for any treatment, procedure, drug, or device is required. When coverage is denied, a letter provided in a timely manner must identify the person making the denial and give the reason for the denial, and outline alternative services, treatment, or procedures.



MEDICAID

Historically, Medicaid payments to physicians have been lower than other third party payors. Rates were based on an arcane formula that often produced fees that barely covered costs. Regardless, KMA understood the limitations of Kentucky's budget and accepted payment rates as they were developed by the state. KMA did not actively lobby the budget making process. We realized that more and more services were being mandated by the federal government, that the universe of people eligible for the program was constantly expanding, and that long term care for the elderly was becoming an increasingly difficult problem.

Medicaid physician payment rates remained essentially unchanged from 1978 through 1988. There was a small increase in 1989 for obstetrical and pediatric care driven by the federal Boren Amendment. On July 1, 1990, there was a slight overall increase for all other physicians.

During the 1991 Special Session, HB 21 instituted a tax on, among others, "fee for service" providers. As HB 21 became law in Kentucky, Medicaid payment rates changed and physicians realized a substantial increase in their payment rates. Physicians also paid a 15% tax on revenues generated from the Medicaid program. At the same time Kentucky, and the Medicaid program specifically, profited from the provider tax. For every \$4.00 raised, Medicaid kept \$2.00 and this occurred without use of general fund dollars.

In 1991 physicians began to see new tax dollars flowing into the Medicaid program. Half of those dollars, right off the top, went to help the program generally. Other monies brought to a reasonable level, rates that had not been updated for ten years. This made participation in the Medicaid program more attractive to physicians and enhanced access to care for Medicaid eligible patients.

A Special Session of the General Assembly in May 1993, enacted HB 1, which levied a 2% tax on physician services. Physicians were prohibited from passing on this tax to the recipient of the health care services. The express purpose of this tax was to help fund the Medicaid program, which was described by the Administration as "nearly bankrupt." In the summer of 1993, shortly after the tax was enacted, Medicaid announced a \$139 million budget surplus. Despite this surplus, physician reimbursement did not increase nor was implementation of the tax halted.

The 1994 General Assembly included a 2% provider tax as part of HB 250, Kentucky's so-called health systems reform measure. This tax was sold to physicians as the only alternative to keep Medicaid solvent and reimbursement at a reasonable level. Shortly after this tax was enacted, physician Medicaid reimbursement was slashed some \$52 million. Despite a legal challenge, these cuts remained in effect.

Kentucky physicians receive approximately 9 cents of the Medicaid dollar, compared to 19 cents of the health care dollar spent nationally. Despite Medicaid's historically low reimbursement rate and the provider tax, KMA has consistently urged physicians to participate in the program and treat patients regardless of their ability to pay. The Association has been the cornerstone of the Kentucky Physicians Care Program which has referred over 55,000 patients to physicians who have treated them without charge. Over 60% of KMA members participate in the KPC program with over 250,000 physician/patient encounters.

Kentucky physicians have made a strong and positive contribution to caring for Kentucky's poor. Our activities with respect to Medicaid and the Kentucky Physicians Care Program attest to that.

Medicaid Facts

- Most physicians receive less than \$5,000 per yr (59.9%)
- Nearly 70% receive less than \$10,000 per year
- Many physicians receive \$25.00 or less per patient
- Drs rank 24th of 44 providers in average pay per patient
- Physicians are paid less than transportation providers
- Physicians receive only 14% of Medicaid expenditures
- Physicians treated 2,110,559 Medicaid patients in 1994
- High usage = misleading "total physician payment" figure
- % of Drs with large Medicaid practices is minuscule
- Only 208 (3.5%) received \$100,000 or more in FY 1994

In 1995, Kentucky received permission from the federal government to move the state's Medicaid system into a new managed care program. This is a unique project unlike any other in the country. The state is essentially turning the Medicaid program over to Kentucky's medical providers by dividing the state into eight geographic regions, with each region having its own infrastructure and program, called "Partnerships." The state will pay each region a per member-per month fee to fund the operation of each Partnership.

The KMA has expressed its concerns about this new system, which center around the difficulty of forming managed care entities in rural areas of the state where there has been little managed care penetration. The state has said that if a region does not form a Partnership, the Medicaid system in that region will be put "up for bid" to private industry.

Today's Physician

Specialty distribution:

- 35% primary care, with only 17% internal medicine, 8.5% family practice, plus ob/gyn and pediatrics
- 5% are general surgeons
- other big specialties are psychiatry, anesthesiology, radiology, emergency medicine, orthopedic surgery, ophthalmology, cardiovascular disease



PROVIDER TAX

Between 1991 and 1993, Kentucky obtained a portion of funding for its Medicaid program through a tax on physicians. This taxing mechanism was known as HB 21. This tax was imposed only on physicians voluntarily participating in the Medicaid program, and was equal in amount to one-half (1/2) of the increase in revenues realized by the participating physician as a result of the July 1, 1991, Medicaid fee update (not to exceed 15% of the physician's gross Medicaid revenue for each calendar quarter). The Kentucky law further provided that any Medicaid participating physician would be reimbursed for the entire amount of the tax from the Medicaid fund. Thus, the physicians and other health care providers serving Medicaid patients were held harmless for the tax.

Under a 1991 amendment to federal law, the amount of state expenditures recognized by the federal government for purposes of determining matching funds was reduced by the amount of any health care related tax found to be impermissible under the amendment. Under this amendment, a state health care related tax is permissible if it is broad based, uniformly imposed, and does not hold the state health care taxpayers harmless for their tax costs.

Kentucky's tax on health care professionals, as it existed under the HB 21 taxing mechanism, constituted an impermissible state tax for purposes of the 1991 amendment since it purported to hold taxpayers harmless for the tax. The effect of this impermissibility was to risk that portion of Kentucky's Medicaid expenditures based on the tax on health care professionals (including physicians) participating in Medicaid. Any impermissible tax receipts would be disregarded by the federal program, which in turn would mean a reduced level of matching funds to fund Kentucky's Medicaid program.

The intent of the 1993 Special Session of the General Assembly in enacting HB 1 was to impose a tax on health care providers in a manner consistent with the 1991 amendment to federal law, in order to maintain the state's level of Medicaid expenditures so as not to suffer a reduction in the level of federal matching funds.

HB 1 imposed a 2% tax on the gross revenues of providers of physician services, nursing facility services, intermediate care facility services for the mentally retarded, home health care services, and health maintenance organization services. Physicians were specifically prohibited from passing this tax on to the recipient of the health care services.

Prior to the implementation of HB 1 on July 1, 1993, the KMA Board of Trustees voted to mount a legal challenge to the constitutionality of this law. This tax was ultimately determined to be constitutional by the state and federal courts.

The Kentucky General Assembly, during its 1994 Regular Session, included a provider tax provision in HB 250. This tax replaced the HB 1 version of the provider tax on July 15, 1994. The 1996 provider tax was imposed on physicians at a rate of 2% on gross revenues. "Gross revenues" were defined as a total amount received in money or otherwise by a provider for the provision of health care items or services in Kentucky, less certain exemptions.

Conspicuous by its absence in the HB 250 version of the provider tax was a prohibition on passing the tax on to the recipient of the service or any third party. For all practical purposes, this silence was interpreted to mean that physicians could not pass the tax on to the recipient of health care services.

KMA has always opposed a provider tax. Reliance on such a mechanism as a long-term, stable source of funding for an ever-expanding Medicaid program is not logical. Kentucky physicians already subsidize a substantial portion of the cost of health care for the indigent. Physicians routinely treat not only Medicaid patients, but also patients who have no insurance, and they will continue to do so regardless of the patient's ability to pay. Physicians stand ready to contribute their "fair share," but to shoulder the entire burden is unfair.

Provider Tax Facts

- Physicians paid 24% of amount collected through tax
- Physicians received only 14% of Medicaid expenditures
- Assessment exceeded 4% of most physicians Net Income
- Tax paid exceeded fees received for most physicians
- Physicians not in Medicaid program paid tax
- KY was 1 of only 3 states with provider tax on physicians
- Only KY & W. WA levied tax on gross receipts
- Tax was a negative for physician recruitment

***KMA** — The Kentucky Medical Association established the repeal of the physician component of the provider tax as its major objective. The 1996 Kentucky General Assembly responded and adopted House Bill 397 which incorporated a phase out of the tax over a three year period. The tax was totally repealed effective July 1, 1999.*



2000

MEDICAL LIABILITY— *A History of Legislation in Kentucky*

During the mid-1970s, Kentucky, like many other states, was caught in a medical liability crisis. The market for professional liability coverage began to shrink. If coverage was available, its price was prohibitive.

When the General Assembly convened in 1976, Kentucky legislators were acutely aware of the problem. At KMA's request, a special task force appointed by the Governor studied the situation for months.

Kentucky's General Assembly responded in 1976 by passing legislation which:

- Eliminated the Ad damnum clause
- Provided that an advance payment could not be used as evidence to show admission of liability on the part of the physician or the insurance carrier
- Adopted the Statute of Frauds, allowing no liability for guarantees unless submitted to the patient in writing
- Codified informed consent into law
- Ensured the confidentiality of peer review
- Established a patient compensation fund, requiring all physicians and hospitals to belong
- Created a joint underwriting association for providers to obtain coverage
- Required reporting of all claims, settled or adjudicated, to the state Insurance Commissioner.

In 1977, the Kentucky Supreme Court ruled that provisions relating to the creation and maintenance of the Patient's Compensation Fund were unconstitutional. The Court also declared that the amendment establishing peer review confidentiality was unconstitutional because the amendment was not germane to the title of the enacting legislation.

The 1978 General Assembly re-enacted legislation regarding peer review confidentiality.

In 1978, the Kentucky Medical Association founded Kentucky Medical Insurance Company. Today, it insures approximately 50% of Kentucky's practicing physicians.

In 1980, the liability crisis reappeared, and KMA sought legislative relief from the 1986 General Assembly. The KMA supported legislation to limit awards, limit noneconomic awards, reduce statute of limitations for minors, and establish periodic payments. None of the KMA-supported measures were passed.

In 1988, the KMA joined with over 20 professional and business organizations to present legislation to resolve the liability crisis. The legislation included proposals to modify the tort system and strengthen insurance laws and regulations. The reform legislation included the following tort reforms relating to physicians liability claims:

- Joint and Several Liability
- Standards of Conduct for Punitive Damages
- Collateral Source Rule
- Standards of Conduct for Officers and Directors of For-Profit Corporations and Officers, Directors, and Volunteers of Non-Profit Corporations and Charitable Organizations
- Confidentiality of Peer Review Records
- Antitrust Immunity for Peer Review and Centralized Reporting of Liability Claims

GOALS FOR THE 2000 KENTUCKY GENERAL ASSEMBLY

PATIENT PROTECTION/PROVIDER FAIRNESS

During the 2000 Kentucky General Assembly (KGA), the KMA plans to enhance the Patient Protection-Provider Fairness provisions enacted during the 1998 KGA, by recommending the adoption of the following initiatives.

Independent External Appeals

Independent external appeals programs should be established to provide an independent medical necessity or appropriateness of service review of final decisions by insurers to deny, reduce, or terminate benefits. Appeals should be determined by physicians practicing in the same state as the insured who is appealing. Physicians involved in the review process should be independent of the carrier. Physicians who act without malice or fraud and within the scope and function of the review process, should be immune from liability for decisions rendered. The cost of external appeals should be borne by the carriers.

Prompt Payment

Managed care plans or licensed insurers must pay a written claim submitted by physicians within 30 days of receipt of fully documented clean claim. Payers should be required to notify physicians within 30 days if a claim is inadequately prepared. Otherwise the claim is presumed valid. Payments for electronically filed claims should be paid within 15 days. If plans fail to remit payment as required, interest may be added at 12% per annum added to the amount owed on the fully documented clean claim. The KMA recommends that the Department of Insurance (DOI) adopt regulations that define a "clean claim." The law should apply to all third party payers including those under the federal ERISA law and the statutes should be rigidly enforced.

All or Nothing Clauses in Managed Care Contracts

Prohibit managed care networks from tying arrangements that require, by coercion or intimidation, physi-



cians to agree to participate in all health care or managed care plans operated by the insurance company or managed care entity. Under "all product clause" arrangements, in order for a physician to participate in one or more plans operated by the company or managed care entity, they must participate in all operable and future plans the company markets. Physicians shall be free to choose the plans or policies in which to participate, and the choice shall not be grounds for denying participation in any chosen plan or policy.

Definition of Medical Necessity

The KMA supports the position that only physicians may determine medical necessity. Medical necessity is clearly defined as health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms:

- (1) In accordance with generally accepted standards of medical practice
- (2) Clinically appropriate in terms of type, frequency, extent, site and duration
- (3) Not primarily for the convenience of the patient, physician, or other health care provider

Exclusive Contracts

Prohibit HMOs from offering contractual provisions which prohibit physicians from becoming a participating provider on a panel outside of the HMO he or she has contracted with (prohibits physicians from being locked onto one HMO panel).

HMO Contracts

Prohibit HMOs from altering services or benefits provided during the term of the group insurance contract. Changes to covered services or benefits must be proposed at least 45 days prior to the group's contract renewal date.

Downcoding

Prohibit insurers from "recoding" or "downcoding" a procedure submitted by a physician, on a claim for covered services provided to an insured. Insurers should be prohibited from downcoding a claim to a different classification code without meeting certain conditions. A health insurer must provide written notice to the insured and the provider that the insurer has recoded the claim, accompanied with appropriate supporting information to justify the change.

Accountability for Medical Decisions

Physicians and employees of health plans and insurers should be fully accountable for demonstrated injury or death resulting from negligent medical decision-making regarding covered services. Physicians employed by third-party payers who make coverage decisions based on "medical necessity" are acting within the professional sphere of a physician and their conduct should fall within the purview of the Board of Medical Licensure.

Mandatory Hospitalist Programs

Mandatory hospitalist programs should be prohibited. Some managed care programs are denying patients the right to have their personal physician care for them in the hospital by establishing mandatory hospitalist programs. Mandatory hospitalist programs require that a patient's regular physician transfer complete responsibility for patient care to a hospital-based physician upon entering the hospital.

HEALTH AND SAFETY

Public Health

The KMA discourages the use of tobacco among all Kentuckians and supports legislation to prevent children's access, purchase, and use of tobacco. Drug, alcohol, and domestic abuse preventive programs and treatments should be available. The KMA urges passage and stringent enforcement of traffic safety legislation, including the required use of helmets by motorcyclists and bicyclists, prohibit minors from riding in open vehicles on state highways, and stringent enforcement of driving under influence laws. The KMA supports mandatory health education (K-12) and sex education beginning in grades 5-7.

Universal Vaccine Program

The KMA supports efforts to make Kentucky a Universal Vaccine State. State school entry laws require that children be immunized against nine vaccine-preventable childhood diseases when they begin kindergarten or first grade. Prohibitive costs and lack of insurance coverage are forcing parents to accept fragmented care for their children. The program would be financed through a budgetary request of \$1.5 to 2.0 million for the biennium. Vaccines can then be purchased at reduced rates and provided free with only a reasonable administration fee.



Tort Reform

KMA supports a Constitutional Amendment to permit the General Assembly to place a limitation on non-economic awards.

Section 54 of Kentucky's Constitution states,

"The General Assembly shall have no power to limit the amount to be recovered for injuries resulting in death, or for injuries to person or property."

The KMA proposes the following amendment to Section 54:

"The General Assembly shall have no power to limit the amount to be recovered for economic loss, including medical expenses, property damage, and lost earnings arising from injuries resulting in death, or for injuries to person or property. The General Assembly shall have the power to limit the amount to be recovered for noneconomic loss, punitive damages, and all other nonpecuniary damage arising from injuries resulting in death or from injuries to person or property. The General Assembly shall also have the power to prescribe the manner in which damages shall be paid."

Talking points in support of limits on noneconomic Limits:

- A 1995 survey indicated that almost two-thirds of Kentucky voters favor limiting noneconomic damages in civil lawsuits. Only 27% opposed.
- A cap on noneconomic damages in no way takes away a patient's right to sue in the event of a medical injury. Injured patients should be compensated for the cost of their care, present and future wages and other economic losses. Patients have an unequivocal right to be made whole.
- No other developed country compensates victims of health care injuries as generously for their noneconomic losses. Even with a cap of \$250,000, we would be the most generous country in the world in terms of noneconomic damage awards.
- The Physician Payment Review Commission in its 1994 Report to the Congress stated that "Much of the unpredictability and inconsistency that characterize today's malpractice awards is because of noneconomic damages (i.e. pain and suffering), which account for about 50% of total payments. Approximately half of the states have statutory limits on noneconomic damages.
- According to the Danzon study a cap on noneconomic damages reduced claims severity 23% on average over the decade in which claims were studied.

- The GAO found that just 2% of medical liability cases produce the large awards for “pain and suffering” damages, yet these cases accounted for over 60% of the payouts.
- According to the Office of Technology Assessment (OTA) limits on noneconomic damages are the single most effective reform in containing medical liability premiums.
- Prior to enactment of a \$250,000 ceiling on noneconomic damages in California, the state had the highest liability premiums in the US. California’s premiums are now one third to one half of those in New York and Florida and other states without limits.
- According to the Institute of Medicine study, the delivery of obstetrical care in all rural areas is seriously threatened by professional liability concerns.
- According to a RAND Corporation study plaintiffs keep only 43 cents of every dollar spent on medical liability. The remainder goes to lawyers.
- A cap on noneconomic damages encourages more expeditious resolution of cases. Settlements should be encouraged rather than continuing the “lottery mentality” which favors lawyers by awarding arbitrary and unpredictable noneconomic damages.
- 71% of Americans support limits on noneconomic damages according to a 1995 poll.
- 77% believe malpractice lawsuits are an important reason for the rising costs of health care.



2000

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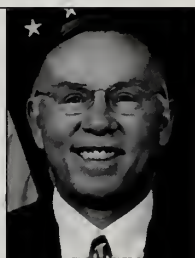
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2000

AMA/KMA CONGRESSIONAL AGENDA

Both Democrats and Republicans recognize that it is vital for the Congress to address the various legislative issues and concerns facing America. Central among Republican and Democratic priorities are many issues of immediate concern to organized medicine. The Administration, Senate and House all have varying proposals for a Patient's Bill of Rights, and patient protection legislation. While organized medicine will face many issues, we will aggressively pursue congressional action on some of medicine's key issues including protecting the confidentiality of medical records, seeking solutions to end-of-life care, and enacting medical liability reforms.

The AMA/KMA will be working aggressively on the following issues:

- **Managed Care Reform** — The environment appears to have improved for passage of a Patients' Bill of Rights, one of the AMA's top priorities from the last few years. In addition to patient protection legislation, Medical Savings Accounts (MSAs) are also expected to be a part of the debate.
- **Antitrust Relief** — Organized medicine will seek to empower individual self-employed physicians with the ability to engage in joint negotiations with health plans.
- **Medicare Fraud and Abuse** — The AMA is preparing an intensive campaign to refocus fraud and abuse enforcement efforts to that honest, law-abiding physicians are not coerced into paying huge financial penalties for inadvertent billing errors.
- **Regulatory Relief** — With HCFA's regulatory burdens and hassle factor out of control, the AMA will push for changes to the Stark self-referral laws, seek to ease CLIA requirements for physician offices, and target other counter-productive regulatory burdens.
- **Health Insurance Reform** — The AMA will seek changes in the federal tax code that will facilitate the transition from an employer-based to an individually-owned insurance system. Such a change would empower patients, preserve the patient-physician relationship and facilitate the development of a new strategies to extend coverage to the uninsured.
- **Medicare Reform** — The National Bipartisan Commission on the Future of Medicare was unable to reach a con-

sensus and has completed its assigned task without making any specific recommendations to the U.S. Congress. However, organized medicine will continue to work with Congress to enact reforms that will assure the long-term solvency of the program. In addition, we will seek a new physician payment update formula that will better reflect the true costs of providing medical services.

- **New Knowledge for Clinical Practice** — The AMA will fight to secure federal funding for scientific research that facilitates the rapid introduction of medical practices to improve patient care.
- **Public Health Initiatives** — The AMA will continue to seek passage of legislation establishing Food and Drug Administration (FDA) authority to regulate tobacco and work on other evolving public health priorities.
- **Confidentiality of Patient Records**

TODAY'S PHYSICIAN

In US

756,710

- 78% male,
22% female
- 46% under age 45
- 23% are IMGs
- 89% in metro areas

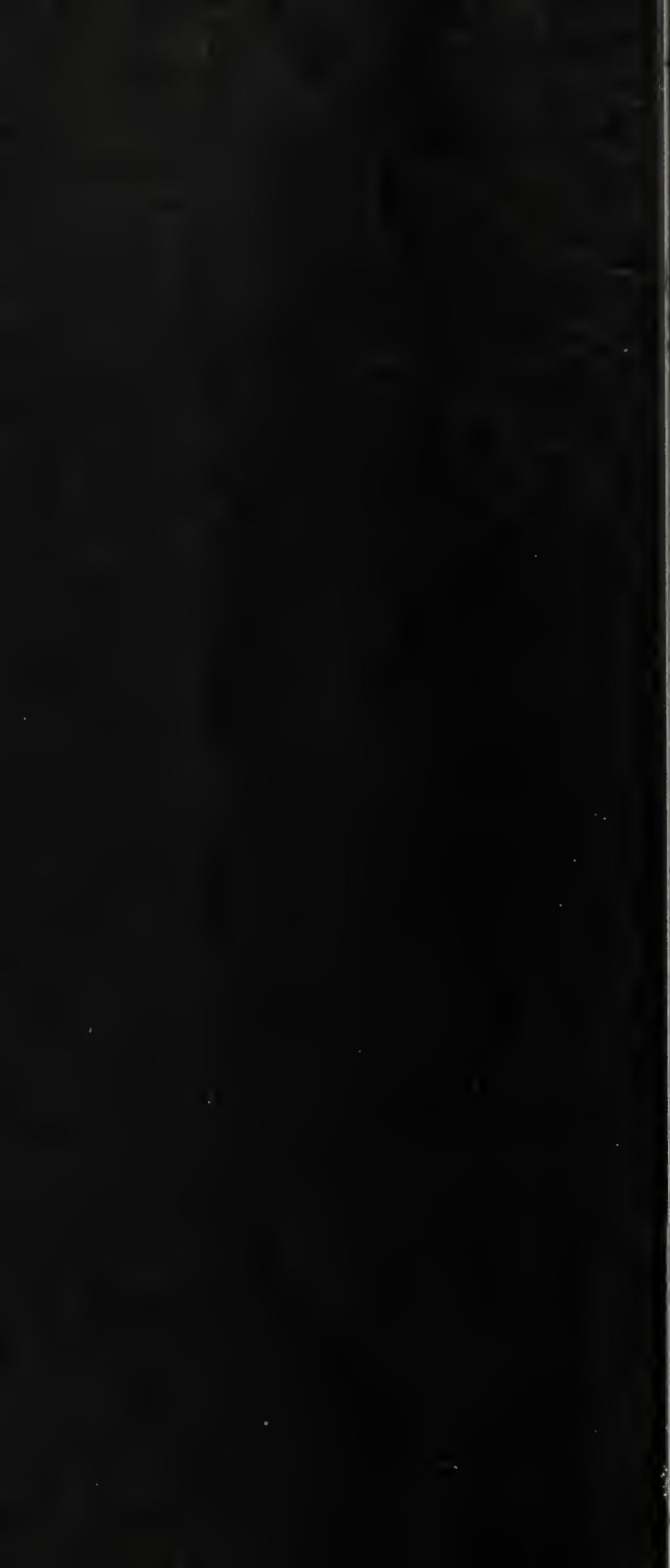
In KY

6,818

- 81% male,
19% female
- 46% under age 45
- 19% are IMGs
- 56% in metro areas

Significant Trends:

- Percent in primary care declined 5% from 1980
- Proportion of IMGs has increased, so proportion of USMGs declined
- Proportion of female physicians tripled 1970 (8%) to 1997 (22%)
 - ➡ number of female physicians increased 207% from 1980-97
 - ➡ 37% of residents are female
- The number of physician group practices has increased by 360% since 1965
- Average group size increased until 1991, then declined. More recent trend is moderate size groups of 5-99 physicians.





ON-CALL

502.426.6200

Who to Call at the Kentucky Medical Association

We hope a listing of KMA staff assignments and individuals who can respond to your inquiries is helpful.

Address Change	Kellie Hardin
AMA Delegation	Bob Klinglesmith
Annual Meeting	
House of Delegates	Bill Applegate
KEMPAC Seminar	Jeanette Thompson
Meeting Facilities and Format	Debbie Best
Nominating Committee	Bill Applegate/Debbie Best
President's Luncheon	Debbie Best
Reference Committees/Resolutions	Bob Klinglesmith
Rules Committee	Bob Klinglesmith/Sharon Heckel
Scientific/Health Education/Technical Exhibits	Debbie Best
Scientific and Specialty Group Programs	Debbie Best
Alliance Kentucky Medical Association	Hope Proctor
Billing	Diane Maxey
Board of Trustees	Bill Applegate
Committees	
Awards	Don Chasteen/Jeanette Thompson
Cancer	Bob Klinglesmith/Sharon Heckel
Care for the Elderly	Bob Klinglesmith/Sharon Heckel
Child and School Health	Bob Klinglesmith/Sharon Heckel
Community and Rural Health	Diane Maxey/Teresa Harper
Complementary/Alternative Medicine	Don Chasteen/Jeanette Thompson
Continuing Medical Education	Diane Maxey/Teresa Harper
Domestic Violence	Diane Maxey/Teresa Harper
Interspecialty Council	Diane Maxey/Teresa Harper
Judicial Council	Pat Padgett/Michelle Phelps
Managed Care	Pat Padgett/Michelle Phelps
Maternal and Neonatal Health	Bob Klinglesmith/Sharon Heckel
Maternal Mortality Committee	Debbie Best
McDowell House	Pat Padgett/Michelle Phelps
Medicaid Managed Care	Pat Padgett/Michelle Phelps
Membership Task Force	Diane Maxey
Organized Medical Staff Section	Bob Klinglesmith/Sharon Heckel
Public Education	Don Chasteen/Marty White/Jeanette Thompson
Physician Advisory to Health Kentucky	Marty White/Jean Wayne
Physician Workforce	Diane Maxey/Teresa Harper
Physical Education/Medical Aspects of Sports	Bob Klinglesmith/Sharon Heckel
Professional Liability	Pat Padgett/Michelle Phelps
Student Section	Wendy Hawes
Resident Section	Wendy Hawes
Trends	Pat Padgett/Michelle Phelps
Young Physicians	Bob Klinglesmith/Sharon Heckel
Communicator	Diane Maxey/Teresa Harper
Complaints	Bob Klinglesmith
Computer Operations	Rose Hibbs
Dues	Wendy Hawes



Employee Benefits	Marsha Harrington/Diane Lundborn
Financial Operations	Marsha Harrington/Diane Lundborn
Vendor Invoices/Accounts Payable	Diane Lundborn
General Inquiries/Information	Sherry Capito
KCHIP	Bob Klinglesmith/Sharon Heckel
Journal	Sue Thorp/Hope Proctor
KEMPAC	
Administration	Jeanette Thompson
Political Consultant	Don Chasteen
Label Requests	Kellie Hardin
Legislation	
National	Don Chasteen/Marty White/Jeanette Thompson
State	Don Chasteen/Marty White/Jeanette Thompson
Mail Room	Don Brinley
Medical/Legal Matters	Pat Padgett
Medicare	Pat Padgett
Medicaid	Pat Padgett
Member Services	Diane Maxey
Membership Recruitment and Retention	Diane Maxey
Physician Addresses	Kellie Hardin
Practice Management Seminars and Workshops	Marty White/Jean Wayne
Print Shop	Rick Hahn/Don Brinley
Public and Media Relations	Don Chasteen/Marty White
Rural Kentucky Medical Scholarship Fund	Michelle Phelps
Specialty Society Services	Teresa Harper
Trustee District Meetings	Marty White/Jean Wayne
Workers Compensation	Pat Padgett

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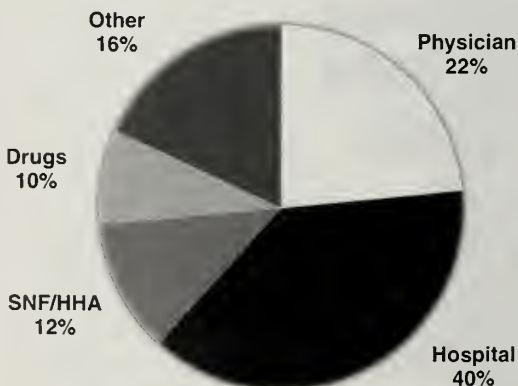


2000

Significant Trends in the Physician Marketplace

- 94% of physicians have managed care contracts
- 52% of practice revenue is from managed care, but only 8% is from capitation
- Most managed care plans pay physicians on a FFS basis, and virtually all of them tie their payment schedules to the Medicare physician payment schedule including private, Medicaid, CHAMPUS
- Medicare FFS physician payments are 30% below private sector rates
- From 1991–97, Medicare payments to physicians fell 10% behind inflation in the costs of medical practice

Where Do U.S. Health Care Dollars Go?



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HAVE NEVER TREATED A PATIENT . . .***



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If your practice is incorporated, KEMPAC and AMPAC voluntary political contributions should be written on a **PERSONAL CHECK**. Contributions are not limited to the suggested amount. Neither the AMA nor the KMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. A portion of voluntary political contributions will be used in connection with federal elections and are subject to the prohibitions and limitations of the Federal Election Campaign Act. Contributions to KEMPAC and AMPAC are not deductible as charitable contributions for federal income tax purposes.



Cover art by Lee Wade of Eminence

Supplement to September 1999

Journal of the Kentucky Medical Association

